

***United States Court of Appeals
for the Second Circuit***



**APPELLANT'S
APPENDIX**

76-6078

UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

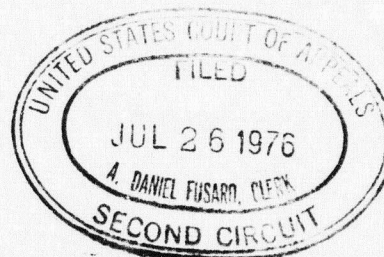
LILLIAN GOLDBERG,

Appellant,

-against-

CASPAR WEINBERGER, Secretary of
Health, Education, and Welfare,

Appellee.



APPENDIX PURSUANT TO SECTION 30(2) OF
THE LOCAL RULES OF THE SECOND CIRCUIT

DAVID S. PREMINGER
Legal Services for the
Elderly Poor
2095 Broadway, Room 304
New York, New York 10023
(212) 595-1340

JOHN C. GRAY, JR.
Brooklyn Legal Services
Corp. B
152 Court Street
Brooklyn, New York, 11201

Attorneys for Appellant

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF NEW YORK

LILLIAN GOLDBERG

Plaintiff

vs.

Civil Action No. 74C 157

CASPAR WEINBERGER,
SECRETARY OF HEALTH,
EDUCATION, AND WELFARE,

Defendant

C E R T I F I C A T I O N

I, H. Dale Cook, Chairman, Appeals Council and Director, Bureau of Hearings and Appeals, Social Security Administration, Department of Health, Education, and Welfare, under authority conferred upon me by the Secretary, hereby certify that the documents annexed hereto constitute a full and accurate transcript of the entire record of proceedings relating to the claim of Lillian Kaufman Goldberg for widow's insurance benefits under title II of the Social Security Act, as amended, such transcript including application for benefits, testimony and other evidence upon which the decision of the administrative law judge and the Appeals Council, Social Security Administration, was based.

Date: March 20, 1974

H. Dale Cook
H. Dale Cook

Lillian Kaufman Goldberg, Claimant
Murray Kaufman, Wage Earner (Deceased)
Account Number 065-01-5460

COURT TRANSCRIPT INDEX

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Lillian Goldberg
(Claimant)

065-01-5460
(Social Security Number)

1

Murray Kaufman

(Wage Earner) (Leave blank if same as above)

EXHIBITS

EXHIBIT NO.	DESCRIPTION	NO. OF PAGES	COURT TRANSCRIPT PAGE NO.
1	Application for Widow's Insurance Benefits, filed 3/10/69	4	38-41
2	Application for Social Security Account Number, dated 2/2/36	1	42
3	Statement Regarding Disability by Widow, filed 3/10/69	2	43-44
3a	Photocopy of Wage Earner Murray Kaufman's Death Certificate, dated 2/12/69	1	45
4	Statement of Death by Funeral Director, dated 2/14/69, Date of Death, 2/12/69	1	46
5	Disability Determination and Transmittal, dated 5/21/69 CLAIMANT UNDER DISABILITY SINCE 10/1/68, TO CONTINUING	2	47-48
6	Request for Reconsideration, dated 7/26/72, with attached Notice of Overpayment due to Remarriage, dated 7/14/72	2	49-50
7	Copy of Reconsideration Determination, dated 11/7/72	2	51-52
8	Copy of Notice of Reconsideration Determination, dated 11/7/72	1	53
9	Earnings Certification, certified 3/24/69	1	54
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11	Photocopy of Form W-2, Wage and Tax Statement for 1968	1	57
12	Photocopy of Marriage Certificate, dated 1/15/36, with Jewish Certificate translated into English	2	58-59
13	Photocopy of Claimant's Birth certificate, dated 10/17/56 - birth date, 7/15/12	1	60
14	Report of Disability Interview by Flatbush D.O., dated 3/10/69	4	61-64
15	Report of Contact by New York State Bureau of Disability Determinations, dated 4/23/69	1	65

Lillian Goldberg
(Claimant)

065-01-5460
(Social Security Number)

Murray Kaufman

(Wage Earner) (Leave blank if same as above)

EXHIBITS (CONT'D)

<u>EXHIBIT NO.</u>	<u>DESCRIPTION</u>	<u>COURT TRANSCRIPT</u>	
		<u>NO. OF PAGES</u>	<u>PAGE NO.</u>
16	Report of Contact by State of New York Bureau of Disability Determinations, dated 5/1/69	1	66
17	Social Security Reporting Card, dated 5/16/72	1	67
18	Consultative Report by Harold Mandelbaum, M.D., dated 3/5/69, with attached copy of Dr. Oliva's Letter to Dr. Mandelbaum, dated 4/14/69	6	68-73
19	Professional Qualifications, Harold Mandelbaum, M.D.	1	74
20	Report by Kings Highway Hospital, Brooklyn, New York, dated 3/13/69	1	75
21	Medical Report by Jules Cinder, M.D., dated 3/20/69 - first visit, 1965 - last visit, 3/17/69	3	76-78
22	Professional Qualifications, Julius Cinder, M. D.	1	79
<u>RECEIVED DURING HEARING:</u>			
23	Without Fault Questionnaire and Refund Questionnaire Signed by claimant, dated 5/9/73	5	80-84



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
P.O. BOX 2518, WASHINGTON, D.C. 20013

3

REFER TO:

IHA-2
065-01-5460

BUREAU OF
HEARINGS AND APPEALS

ACTION OF APPEALS COUNCIL ON REQUEST FOR REVIEW

Mrs. Lillian Goldberg
1225 Ocean Parkway
Brooklyn, New York 11230

Dear Mrs. Goldberg:

Your request for review of the administrative law judge's decision has been carefully considered by the Appeals Council. The Council's consideration of your request has included all the evidence in your case, the law and regulations applicable to your claim, the evaluation of the facts and the reasoning in this decision, and your reasons for believing your claim should be allowed.

The Appeals Council has concluded that this decision is correct. Further action by the Council would not, therefore, result in any change which would be of advantage to you. Accordingly, the administrative law judge's decision stands as the final decision of the Secretary in your case.

If you desire a review of the decision by a court, you may commence a civil action in the district court of the United States in the judicial district in which you reside within sixty (60) days from this date. See section 205(g) of the Social Security Act, as amended (section 405(g), Title 42, United States Code). If such action is commenced, the Secretary of Health, Education, and Welfare is the proper defendant.

Sincerely yours,

Irwin Friedenber
Member, Appeals Council

cc:
Mr. Richard A. Kaufman

BEST COPY AVAILABLE



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
P.O. BOX 2518, WASHINGTON, D.C. 20013

4

REFER TO: HA: C
065-01-5460

BUREAU OF
HEARINGS AND APPEALS

Mrs. Lillian Goldberg
1225 Ocean Parkway
Brooklyn, New York 11230

Dear Mrs. Goldberg:

We have received the request for review filed in connection with your claim for benefits. Because of the large number of requests for review now pending before the Appeals Council, there may be some delay before your case is reached.

We regret any inconvenience that this delay may cause, and we will act on your request as soon as possible.

Sincerely yours,

cc:
DO, Brooklyn New York 11226

Irwin A. Friedenberg
Member, Appeals Council

cc:
Mr. Richard A. Kaufman
2456 Kerry Lane
Baltimore, L.I., New York 11710



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
BUREAU OF HEARINGS AND APPEALS

REQUEST FOR REVIEW OF HEARING DECISION/ORDER

Take or mail original and all copies to your local social security office.

5

CLAIMANT
LILLIAN GOLDBERG

WAGE EARNER (Leave blank if same as above)

MURRAY KAUFMAN

SOCIAL SECURITY NUMBER

065-01-5460 D

SPOUSE'S NAME AND SOCIAL SECURITY NUMBER
(Complete ONLY in Supplemental Security Income Case)

CLAIM FOR

☐ Entitlement to Disability Benefits

☒ Continuance of Disability Benefits

☐ Other (Specify) _____

☐ Supplemental Security Income

☐ Continuance of Supplemental Security Income

I disagree with the action taken on the above claim and request review of such action by the Appeals Council, of the Bureau of Hearings and Appeals. My reasons for disagreement are:

I BELIEVE I AM WITHOUT FAULT IN THIS
MATTER & THAT WIDOW'S BENEFITS SHOULD BE
CONTINUED

Attach to this form, or forward within 10 days to the Appeals Council at the address checked below, any evidence you wish to submit.

Signed by: (Either the claimant or representative should sign - Enter addresses for both)

SIGNATURE OR NAME OF CLAIMANT'S REPRESENTATIVE

☐ ATTORNEY

☐ NON-ATTORNEY

CLAIMANT'S SIGNATURE

STREET ADDRESS

STREET ADDRESS

2456 Kerry Lane

1225 Ocean Pkwy

CITY, STATE, AND ZIP CODE

Bellmore NY 11716

CITY, STATE, AND ZIP CODE

BKLY N.Y. 11230

PHONE NUMBER

DATE

9/4/73

TELEPHONE NUMBER

DE 8 6907

Claimant should not fill in below this line

TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION

Is this request filed timely? ☒ Yes ☐ No

" " is checked: (1) attach claimant's explanation for delay; (2) attach any pertinent letter, material or information in Social Security Office.

ACKNOWLEDGMENT OF REQUEST FOR REVIEW OF HEARING DECISION/ORDER

Request for Review of Hearing Decision/Order in this case was filed on 9/4/73 at Floraland N.Y.

The APPEALS COUNCIL will notify you of its action on your request.

☐ Appeals Council
Bureau of Hearings and Appeals, SSA
P.O. Box 2518
Washington, D.C. 20013

☐ Appeals Council
Bureau of Hearings and Appeals, SSA

For the Social Security Administration
BY (Signature) Allen
(Title) CR
(Street Address) 135 E 22 ST
(City) BKLY (State) N.Y. (ZIP Code) 11226

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
BUREAU OF HEARINGS AND APPEALS

6

To: • Lillian Goldberg
1225 Ocean Parkway
Brooklyn, NY 11230

NOTICE OF DECISION

PLEASE READ CAREFULLY

If you disagree, in whole or in part, with the enclosed decision of the hearing examiner, you may request the Appeals Council to review it. However, your request for review must be filed within 60 days following the date shown below.

You, or your representative, may file the request for review at the nearest office of the Social Security Administration, or you may file the request for review with the hearing examiner, or with the Appeals Council.

Unless you file a timely request for review by the Appeals Council, you may not obtain a court review of your case under sections 205 (g) and 1869 (b) of the Social Security Act.

This notice and enclosed copy of hearing
examiner's decision mailed to the claimant on

July 10, 1973

CC:

Name and Address of Representative:

Mr. Richard A. Kaufman
2456 Kerry Lane
Bellmore, L.I., NY 11710

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
BUREAU OF HEARINGS AND APPEALS

7

HEARING DECISION

In the case of

Lillian Goldberg
(Claimant)

Murray Kaufman
(Wage Earner)(Leave blank if same as above)

Claim for

Widow's Insurance Benefits

065-01-5460

(Social Security Number)

This case is before the undersigned Administrative Law Judge upon a timely filed request for hearing by the claimant, Lillian Goldberg who disagrees with the termination of the Social Security Administration ceasing her widow's insurance benefits under sections 202, respectively, of the Social Security Act, as amended.

After due notice, a hearing was held in Brooklyn, New York, on May 8, 1973, at which time the claimant appeared personally and testified. Her son Richard A. Kaufman represented her at the hearing.

PROCEDURAL AND ADJUDICATIVE HISTORY

The claimant filed an application for a period of disability and disability insurance benefits on March 10, 1969, which was initially granted by the Social Security Administration. Upon being notified that the claimant remarried as of May, 1972, her benefits were stopped. The claimant requested reconsideration and by a letter dated November 7, 1972, was informed that the initial denial had been affirmed. The claimant requested a hearing on December 6, 1972.

APPLICABLE LAW AND ISSUES

Section 216(c) of the Act defines the term "widow" as the surviving wife of an individual if she was married to him for a period of not less than nine months immediately prior to the day on which he died, and was the mother of his son or daughter.

Section 202(e) provides that the widow of an individual who died a fully insured individual shall be entitled to widow's insurance benefits if certain conditions are met. Pertinent herein are portions of section 202(e)(1) which reads as follows:

"The widow (as defined in section 216(c))*** of an individual who died a fully insured individual if such widow***

- (A) is not married
- (B) (i) has attained age 60***
- (C) (i) has filed an application for widow's insurance benefits***
- (D) is not entitled to old age benefits . . . shall be entitled to a widow's insurance benefits***"

(4) if a widow, after attaining the age of 60, marries*** such marriage shall for purposes of paragraph (1) of this subsection, be deemed not to have occurred***

Section 202(e)(B)(3) states in pertinent part that a widow who marries an individual entitled to benefits under subsection (f) or (h) of this section.

The general issue to be decided is whether the claimant is entitled to disabled widow's insurance benefits on the account of the late Murray Kaufman beginning May, 1972.

The specific issues are 1) was an overpayment created, 2) was the claimant "without fault" in the creation of this overpayment, 3) may the overpayment be waived.

Section 404:510a of 20 CFR 72 states in pertinent part that a benefit payment under Title II . . . exceeds the amount to which he is entitled, constitutes an entitlement overpayment. Where an individual accepts such overpayment because of reliance on erroneous information from an official source within the Social Security Administration which the individual had come to believe was connected with his benefits and the interpretation of the Regulations . . . such individual shall be deemed to be "without fault."

Section 404:512 states in pertinent part that in the situations described in section 404:510a recovery will be waived since it will be deemed that such adjustment will be "against equity and good conscience."

SUMMARY OF THE CLAIMANT'S TESTIMONY

The claimant was represented at the hearing by her son. He stated that there was agreement as far as the facts were concerned. There is no dispute that his mother was born on July 15, 1912, and attained the age of 60 years on July 15, 1972. There also was agreement that the date of marriage to Mr. Goldberg was May 21, 1972. He, the son, had requested his mother to make inquiry at the Avenue X, Social Security Office, prior to the arrangements for the marriage being formulated. His mother was informed that she would have lesser benefits, but was not given any information about age 60 and the consequences of remarriage prior to that date. His mother was not aware of the halting of benefits until she received notice in July of 1972. She cashed two of the checks amounting to \$265 which were issued prior to the notification by the Social Security local office of the termination of benefits due to remarriage.

EVALUATION OF THE EVIDENCE

There is no dispute concerning the date, the claimant attained age 60, namely July 15, 1972. There is no dispute that the claimant married Mr. Goldberg on May 21, 1972, about three months before she celebrated her 60th birthday. At the urging of her son who was knowledgeable about the possible effects of this marriage upon her disability benefits, she alleges that she contacted the local Social Security Office and was informed that the marriage might reduce her benefits but would not cease them. In other words, her entitlement would not be affected. The claimant is not too clear as to the person that gave her this information, but under all the circumstances her version does not seem unreasonable. Even though the claimant cannot identify the person, the Administrative Law Judge gives full credence to her testimony that she did consult the local Social Security Office prior to her marriage and that she was misinformed as to the effect of her contemplated nuptial arrangements upon the benefits she was receiving.

The right to widow's insurance benefits that the claimant seeks to enforce is one created by statute. To have an enforceable right, the claimant must comply with the statutory requirements. The facts indicate that the

claimant relied upon a misrepresentation of an employee of the local Social Security Office, to her detriment. It is well established that estoppel cannot be set up against the Government on the basis of an unauthorized representation or act of an officer or employee who is without authority in his individual capacity to bind the Government. Byrne Organization Inc. v. United States, 287 F 2d 582, Ewing v. Risher 176 F 2d 641, SSR - 70 - 19c, Terrell v. Finch 302 F Supp 1063 (U.S.D.C.).

The Social Security Act is clear. A widow who remarries before age 60, forfeits her rights to widow's insurance benefits.

The widow received, cashed and spent payments received after the date that her benefits terminated. She did so under the color of right, since she had been paid benefits for several years prior to the checks in question. She relied upon the erroneous advice given to her by an employee of the local Social Security Office. An overpayment in the amount of \$265 was created. Pursuant to section 404:510a of 20 CFR 72, The Administrative Law Judge finds that the claimant having so relied was "without fault." Thus it follows that under Regulation 404:512 recovery of the overpayment will be waived since it will be deemed that such adjustment will be "against equity and good conscience."

FINDINGS AND CONCLUSIONS

From an analysis of all the substantive and credible evidence of record, the Administrative Law Judge makes the following findings and conclusions:

1. The claimant filed an application for a widow's insurance benefits on March 10, 1969, alleging disability from February, 1969, at age 53.
2. The claimant remarried in May, 1972, and attained age 60 on July 15, 1972.
3. By remarrying prior to the attainment of age 60, the claimant lost her right to obtain widow's benefits on the earnings record of her deceased husband, Murray Kaufman.

4. There was an overpayment created in the sum of \$265.

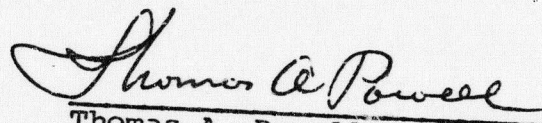
5. The claimant was "without fault" in the creation of such overpayment.

6. The recovery of such overpayment will be waived, since it is "deemed" that such adjustment will be "against equity and good conscience."

DECISION

It is the decision of the Administrative Law Judge that, based on her application filed on March 10, 1969, the claimant is not entitled to widow's insurance benefits under section 202 of the Social Security Act, and it is the further decision of the Administrative Law Judge that recovery will be waived.

Date: JUL 10 1973


Thomas A. Powell
Administrative Law Judge



DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

APPOINTMENT OF REPRESENTATIVE

12

I appoint Richard A. Kaufman, 2456 Kerry Lane, Bellmore, L.I.N.Y. 11710
(Print or Type Name and Address of Representative)
to act as my representative in connection with my claim under Titles II or XVIII of the
Social Security Act based on the social security record of

NAME <u>Lillian Goldberg</u>	SOCIAL SECURITY NUMBER <u>065-01-5460</u>
---------------------------------	--

I authorize him to make or give any request or notice; present or elicit evidence; obtain
information; and receive any notice in connection with my claim wholly in my stead.

Date May 8, 1973

Signature Lillian Goldberg

Address 1225 Ocean Parkway
Brooklyn, N.Y. 11230

ACCEPTANCE OF APPOINTMENT

I, Richard A. Kaufman, hereby accept the above appointment.
I certify that I have not been suspended or prohibited from practice before the Social
Security Administration; that I am not, as an officer or employee of the United States,
disqualified from acting as the claimant's representative; and that I will not charge or
receive a fee for the representation unless it has been authorized in accordance with the
laws and regulations referred to on the reverse side hereof.

I am son

(union representative, relative, etc.)

Date May 8, 1973

Signature

Richard A. Kaufman

Address

2456 Kerry Lane
Bellmore, L.I.N.Y. 11710

(See Important Information on Reverse)

CHARGING OF FEES FOR REPRESENTING SOCIAL SECURITY CLAIMANTS

13

An attorney, or other representative, who wishes to charge a fee for services rendered in connection with a claim before the Social Security Administration is required by law to obtain approval of the fee from the Social Security Administration (section 206(a) of the Social Security Act; Social Security Administration Regulations No. 404.975).

Form SSA-1560, "Petition to Obtain Approval of a Fee For Representing a Social Security Claimant," which elicits the information required to be submitted in support of fee petitions, should be completed by the representative after his services are completed and the original and third carbon copy of the SSA-1560 filed with the office of the Social Security Administration which took the latest action on the claim. The representative is required to furnish a copy (first carbon) of the SSA-1560 petition to the claimant for whom the services were rendered.

Social Security Administration approval of a fee is *not* required where the fee is for services (1) rendered in an official capacity such as that of legal guardian, committee, or similar court-appointed office and the court has approved the fee in question, (2) in representing the claimant before a court of law, or (3) in representing the claimant in a claim for reimbursement of medical expenses exclusively handled by a private intermediary.

Where a representative has rendered services in a claim before the Social Security Administration and a court of law, the regulations require that he specify what, if any, amount of the fee he desires to charge is for services performed before the Administration. If he charges any fee for such services, he must petition for approval of that amount. In this connection a claim which has been remanded by a court to the Administration for further administrative proceedings is considered to be before the Administration after the remand by the court.

AUTHORIZATION OF FEE

The social security regulations contemplate that a representative will receive fair value for his services consistent with the purposes of the social security program, one of which is to give a measure of security to retired people, the disabled, and widows and children. In approving a requested fee, the Administration considers the nature and type of services performed, the complexity of the case, the level of skill and competence required in rendition of the services, the

amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the claim and the amount of the fee requested by the representative. When a fee is authorized, both the representative and the claimant are notified and allowed 30 days in which to request an administrative review in case of disagreement.

PAYMENT OF FEES

Basic liability for payment of a representative's fee rests with the claimant. However, if the representative is an attorney at law and there are past-due benefits awarded to the claimant under title II of the Social Security Act, a portion of the past-due benefits will be paid to the attorney toward payment of the fee. Such payment will be in an amount equal to whichever is the smaller: (1) the amount of the authorized fee; (2) 25 percent of the past-due benefits for months prior to the month in which the favorable determination was made on the claim, or (3) in cases decided below the court level, any amount that may have been agreed upon by the attorney and claimant as the fee for the attorney's services. The law does not permit direct payment to representatives except as indicated above; thus, if the representative is not an attorney at law (or there is an insufficient amount of accrued benefits to cover payment of an attorney's fee) the representative must look to the claimant for payment after his fee has been authorized by the Administration.

PENALTY FOR CHARGING UNAUTHORIZED FEE

Any representative who charges or collects an unauthorized fee for services performed in connection with a social security claim, including services before a court which has rendered a favorable determination, may be subject to prosecution under section 206 of the Social Security Act which provides that such individual, upon conviction thereof, shall for each offense be punished by a fine not exceeding \$500 or by imprisonment not exceeding 1 year, or both.

CONFLICT OF INTEREST

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States.

BEST COPY AVAILABLE

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
BUREAU OF HEARINGS AND APPEALS

NOTICE OF HEARING

14

In the case of

Lillian Goldberg

(Claimant)

Murray Kautman

(Wage Earner)

Claim For
Widow's (Widower's) Insurance
Benefits Based on Disability

065-01-5460

(Social Security Number)

TO: **Mrs. Lillian Goldberg**
1225 Ocean Parkway
Brooklyn, New York 11230

Pursuant to your written request and provisions of section 205(b) of the Social Security Act, a hearing will be held by the undersigned **Administrative Law Judge** of the Bureau of Hearings and Appeals, on the **8th** day of **May, 1973** at **10 AM** o'clock in Room **1201** of **175 Renssen Street** **Brooklyn** **New York** Building.
(Number and Street) (City) (State)

The general issue to be determined is whether you are entitled to widow's (widower's) insurance benefits based on disability under section 202(e) (202(f)) of the Social Security Act, as amended.

The specific issues to be decided are: (1) The date of your spouse's death; (2) whether your spouse had the required insured status under social security at the time of death; (3) the date of your birth; (4) whether your impairment or impairments are of a level of severity which, under regulations prescribed by the Secretary, is deemed to be sufficient to preclude an individual from engaging in any gainful activity; (5) whether your impairment has lasted or can be expected to last for at least 12 months, or can be expected to result in death; (6) when your disability, if any, began.

This hearing involves your application(s) filed on **March 10, 1969**
Remarks: (Date)

IMPORTANT - Please sign the enclosed postal card notifying me whether you will be present at the above time and place. The postal card should be returned at once; no postage is required.

Administrative Law Judge		MAIL ADDRESS
Thomas A. Powell		Room 1201
DATE	TELEPHONE NUMBER	175 Renssen Street
April 25, 1973	596 - 5890	Brooklyn, New York

CC: REPRESENTATIVE (Name and Address)

DISTRICT OFFICE (Address)

Flatbush D.O., 135 E. 22nd St., Bklyn, N.Y. 11226

Enclosure

READ THE OTHER SIDE OF THIS NOTICE FOR FURTHER INFORMATION REGARDING YOUR HEARING.

FORM HA-507.2A
(4-72)

HEARING FILE

(Over)

IMPORTANT INFORMATION
BENEFITS FOR DISABLED WIDOWS AND WIDOWERS

15

General

The Social Security Amendments of 1967 provide benefits for disabled widows, surviving divorced wives, and widowers. These benefits are payable as early as age 50. A widow or surviving divorced wife must have become disabled before age 60, and not later than 7 years after (1) the month of her husband's death, or (2) the last month she was entitled to mother's insurance benefits, or (3) the month in which any previous entitlement to widow's insurance benefits based on disability ended because she was no longer disabled. A widower must have become disabled before age 62 and not later than 7 years after (1) the month of his wife's death, or (2) the month his previous entitlement to widower's insurance benefits based on disability ended because he was no longer disabled.

The Meaning of "Disability" for Widow's
Or Widower's Insurance Benefits

The law provides as in the case of an insured worker that the widow or widower must be unable to engage in any substantial gainful activity due to any medically determinable physical or mental impairment which has lasted or can be expected to last for a continuous period of at least 12 months, or can be expected to result in death. In addition, the physical or mental impairment must be of a level of severity described in regulations issued by the Secretary of Health, Education, and Welfare which is deemed sufficient to preclude an individual from engaging in any gainful activity. If the individual is engaging in substantial gainful activity despite his impairment, he will not be found to be disabled, even if his impairment meets or equals the level of severity described in the regulations.

Other Requirements

Other specific requirements for entitlement to benefits for a disabled widow, surviving divorced wife, or widower, as they apply to your claim, are stated in the remarks section of this notice.

Appearance at Hearing

The date and time of this hearing have been set aside especially for you. Your failure to appear without good reason may cause dismissal of your Request for Hearing. Even though there is good reason, any postponement will delay disposition of your case. If an emergency arises preventing your appearance after you mail the postal card stating that you will be present, notify the Hearing Examiner promptly and give your reasons. Also inform the Hearing Examiner of the earliest date after which he can reschedule your case for hearing.

If you have any other questions, your local social security office will be glad to help you.

Evidence of Disability

The law places on you the burden of submitting evidence to support your claim. You must show the severity of your impairment by available medical evidence, and where necessary by appropriate medical tests. Bring to the hearing any of the following medical evidence which may be available and which has not already been submitted: (a) medical reports from doctors who examined or treated you; (b) reports of laboratory tests; (c) copies of medical reports submitted to insurance companies or the State Compensation Commission; and (d) copies of hospital records. If you have difficulty obtaining any of this evidence, please notify the hearing examiner promptly. If considered necessary for a decision in your case, the hearing examiner may ask you to undergo a medical examination at no expense to you.

Conduct of Hearing

You will have an opportunity to examine the documentary evidence on the day of the hearing. If you wish to examine it before the day of the hearing you may do so at the Hearing Examiner's office.

At the hearing the Hearing Examiner will inquire fully into the matters at issue. You may present evidence either in the form of written documents or the testimony of witnesses, or both. You may bring your own physicians or other witnesses to testify on your behalf. If necessary, the Hearing Examiner may ask the doctor who examined you to appear, and may bring in a medical expert to testify. Your testimony and that of any witnesses will be under oath or affirmation, and a verbatim record of the proceedings will be made. You may suggest findings of fact or conclusions of law and present arguments orally or in writing.

Representation

While it is not required, you may be represented at the hearing by an attorney or other qualified person of your choice, if you desire assistance in presenting your case. Any fee which your representative wishes to charge for his services in your case must be approved by the Bureau of Hearings and Appeals. Your representative must petition for fee approval at the conclusion of his services, and furnish you with a copy of his petition.

If you are found entitled to benefits and your representative is an attorney, 25 percent of your back benefits will normally be withheld for payment to your attorney upon approval of his fee. If the approved fee is less than the 25 percent withheld, the difference will be paid directly to you. If the approved fee is more than 25 percent, payment of the difference is a matter to be settled between you and your attorney.

If your representative is not an attorney, none of your benefits will be withheld; and payment of the fee which is approved is a matter to be settled between you and him.

REQUEST FOR HEARING

DEC 7 1972

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Take or mail original and all copies to your local Social Security office.

CLAIMANT'S NAME

Leah Goldberg

WAGE EARNER'S NAME (Leave blank if same as above)

Murray Kaufman

SOCIAL SECURITY NUMBER

065-01-5460

CLAIM FOR

☐ Entitlement to Disability Benefits (97)

☒ Continuance of Disability Benefits (98)

☐ Other

(Specify type claim)

I disagree with the determination made on the above claim and request a hearing before a hearing examiner of the Bureau of Hearings and Appeals. My reasons for disagreement are:

Since advised by Social Security that my disability benefits would continue at a lesser amount if I remained, no mention was made regarding age at
Check one of the following:
☐ I have additional evidence to submit.
(Attach such evidence to this form or forward to the Social Security Office within 10 days.)
☒ I have no additional evidence to submit.

Check ONLY ONE of the statements below.
☒ I wish to appear in person before the hearing examiner.
remains

☐ I waive my right to appear and give evidence, and hereby request a decision on the evidence before the hearing examiner.

Signed by: (Either the claimant or representative should sign-Enter addresses for both. If claimant's representative is not an attorney, complete Form SSA-1676)

SIGNATURE OR NAME OF CLAIMANT'S REPRESENTATIVE

ADDRESS Department of Health, Education & Welfare
Bureau of Hearings and Appeals

CITY, STATE, AND ZIP CODE NYC 8 1972

TELEPHONE NUMBER 20 Federal Plaza, Rm. 3135
New York, New York 10007

CLAIMANT'S SIGNATURE

Leah Goldberg

ADDRESS

1225 Ocean Parkway

CITY, STATE, AND ZIP CODE

Bklyn NY 11230

TELEPHONE NUMBER

Se-8-6907

Is this request filed within 6 months of the reconsideration determination? ☒ Yes ☐ No
If "No" is checked: (1) attach claimant's explanation for delay, (2) attach any pertinent letter, material, or information in the Social Security Office.

ACKNOWLEDGMENT OF REQUEST FOR HEARING

Your request for a hearing was filed on 12/6/72 at 135 E. 4th St. Bklyn NY
The hearing examiner will notify you of the time and place of the hearing at least 10 days prior to the date which will be set for the hearing.

Hearing Examiner Copy	TO:	<input checked="" type="checkbox"/> Hearing Examiner <u>Mr. Federal Bogen</u>
	TO:	<input type="checkbox"/> Hearing Examiner-Disability file in BDI TELETYPE BDI, BALTIMORE, MD.
	<input type="checkbox"/> Payment Center	(Location)
	<input type="checkbox"/> BHI	(Location)
	<input type="checkbox"/> DFC (BRSI) <input type="checkbox"/> CWAB (BDPA)	
Claim File Copy	Interpreter Needed _____ (Language)	

For the Social Security Administration

By: A. A. A. A. C. R.
(Signature) (Title)
135 E. 4th St
(Street Address)
Bklyn NY 11230
(City) (State) (ZIP Code)

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
BUREAU OF HEARINGS AND APPEALS

17

TRANSCRIPT

In the case of

Claim for

LILLIAN GOLDBERG
(Claimant)

WIDOW'S DISABILITY INSURANCE BENEFITS

MURRAY KAUFMAN
(Wage Earner) (Leave blank if same as above.)

065-01-5460
(Social Security Number)

Hearing Held

at

175 Remsen Street
Brooklyn, New York 11201

on

May 8, 1973

APPEARANCES: Lillian Goldberg, claimant
Richard A. Kaufman, representative

Thomas A. Powell
~~XXXXXX~~
Administrative Law Judge

Walter Lutzak
Hearing Assistant

INDEX OF TRANSCRIPT

In the case of:
Lillian Goldberg

Account Number

Murray Kaufman

065-01-5460

Testimony of:

Lillian Goldberg commencing p. 6

Richard Kaufman commencing p.10

(The following is a transcript of the hearing held before Thomas A. Powell, an Administrative Law Judge of the Bureau of Hearings and Appeals, Social Security Administration, Department of Health, Education, and Welfare, on May 8, 1973, at 175 Remsen Street, Brooklyn, New York, in the case of Lillian Goldberg, claimant in her own behalf, based on the earnings record of Murray Kaufman, deceased wage earner, social security account number 065-01-5460. The claimant, Lillian Goldberg, appeared in person and was represented by her son, Richard A. Kaufman.)

(The hearing commenced at 10:12 a.m., on May 8, 1973.)

OPENING STATEMENT BY ADMINISTRATIVE LAW JUDGE:

ADMINISTRATIVE LAW JUDGE: Now, I understand sir, that you are going to represent your mother in this proceeding.

MR. KAUFMAN: At this stage, sir.

ADMINISTRATIVE LAW JUDGE: Alright, we are ready to proceed with the hearing in the case of Mrs. Lillian Goldberg, nee Kaufman, a claimant for Widow's Disability Insurance Benefits based on her husband's earnings record, Murray Kaufman, social security account number 065-01-5460. Mrs. Goldberg, I am Judge Thomas A. Powell, an Administrative Law Judge for the Bureau of Hearings and Appeals of the Social Security Administration. Now, I am not a representative of the Bureau of Retirement and Survivors Benefits or the Bureau of Disability Benefits, or the Bureau of Disability Insurance of the Social

Security Administration which rendered the prior determination which you are questioning in this proceeding. Now, you were advised in the Notice of Hearing which I sent to you of your right in each and every stage of this proceeding to be represented by a lawyer or other qualified person of your choice and I see you have elected today to have your son Richard A. Kaufman act as your representative. But still under the law I must advise you of your right to be represented by counsel and I assume that this representation by your son is entirely according to your wishes. Is that right?

MRS. GOLDBERG: Yes.

ADMINISTRATIVE LAW JUDGE: Now, I would like to have the opportunity to explain this type of proceeding to you. The purpose of this hearing is to give you the opportunity to present your case to an independent Administrative Law Judge who has had no contact or connection with your case before this time. In other words, your request for a hearing first came to me, and came to my attention shortly after it was sent to my office to conduct a hearing, which hearing was requested

by you. I had no knowledge or connection with this case at the time that the Bureau of Disability Insurance first denied your application nor when upon Reconsideration the Bureau of Disability Insurance again denied your application when reconsideration was made. I am not bound by the two previous denials of your claim. To the contrary, I will make a new and independent decision based upon the exhibits or documents introduced in evidence today and upon your testimony, also in this type of hearing you may after the hearing is concluded submit evidence that is relevant to the issues and based upon all of this testimony, whether you want any witnesses you'll have today, I'll make a decision in writing and a copy will be sent to you, and in this case to the representative.

Now, many times in the proceeding and in my decision you Mrs. Goldberg will be referred to as the "claimant". The hearing will be conducted by me asking you and any other witnesses questions and the answers will be made under oath. Questions should be answered directly, truthfully, and accurately.

When I have finished asking questions, you may or your representative may introduce any additional evidence relative to the

issues in this case, or you might want to testify to matters which might be relevant which I have not covered with my questioning. You or your representative have the right to make any argument you desire and to suggest to the Administrative Law Judge any findings of fact and conclusions of law. The formal rules of evidence normally followed in trial of court cases do not apply in this proceeding. This gentleman Mr. Lutzak present is a hearing assistant and he is here to record and preserve a record of this proceeding. As you can see the matter is being taken down electronically, so witnesses should speak slowly so that the record may be accurate. Now Mrs. Goldberg you and your son have had an opportunity to look over a list of exhibits which I propose to make a part of the record of this proceeding. They are numbered 1 through 22. These exhibits are pertinent documents which I have selected from your social security file. They were shown to you by the hearing assistant before the hearing commenced. Now, do you agree for them to be admitted into evidence of this hearing.

MR. KAUFMAN: Yes.

ADMINISTRATIVE LAW JUDGE: Being no objections to the exhibits, they will be admitted in evidence and marked Exhibits 1 to 22 respectively. Now, if you desire a recess during any part of these proceedings, just indicate that fact to me and I will take it up at that time. I will now summarize the record in this case up to the present time before I begin my questioning of you and your witnesses. On March 10, 1969, you, the claimant filed an application for Widow's Disability Insurance Benefits and also to Widow's Insurance Benefits. You allege you became unable to work since 1965 and you were awarded Widow's Disability Benefits since October 1, 1968 to continue till July 14, 1972.

MRS. GOLDBERG: Yes.

ADMINISTRATIVE LAW JUDGE: Now then it appears from the record that in May of 1972 you remarried, to Mr. Goldberg and that in that same year in July of '72 you obtained the age of 60. So that pursuant to section 202(e) of the Social Security Act your Social Security Benefits and Disability Benefits were terminated, because of the fact that you married prior to age 60. That same law, section 202 provides that if a widow marries

after the age of 60 her benefits are reduced but marriage is deemed not to have taken place. So at this time I am going to ask you to stand and raise your right hand.

The claimant, LILLIAN GOLDBERG, having been first been duly sworn, testified as follows:

EXAMINATION BY ADMINISTRATIVE LAW JUDGE:

Q To begin with since your application has there been any change in your physical condition?

A No, it's just that I go every three months for my checkups and he has a few other findings which have not been disclosed to me but it is imperative that I keep going.

Q I see.

A The heart has become enlarged, thyroid is enlarged. That's as much as I know.

Q Now it appears that you have also been notified in this case that there has been an overpayment of \$265. Is that right?

A Yes, that's right.

Q So the issues that we have before us for determination today is whether or not you are entitled to a continuance of

Widow's Disability Benefits.

A Yes, that's right.

Q That number 1 and number 2 is to whether or not the overpayment may be waived. Are you getting any Social Security Benefits at the moment?

A No.

Q Now, what date did you marry Mr. Goldberg?

A May 21, 1971, 1972, I'm sorry.

Q Now you became age 61.

A July 15th of the same year.

Q And how did the overpayment arise? Did you keep getting checks?

A I got two checks.

Q Which you kept and cashed?

A Yes.

Q And they have together amounted to \$265?

A I'm not sure of the exact amount.

MR. KAUFMAN: Judge, may I say something please?

ADMINISTRATIVE LAW JUDGE: Certainly.

MR. KAUFMAN: The checks were received and cashed solely

because the actual termination itself wasn't received until mid July, 1972. My mother had no notice before then that they had made a termination of her award, otherwise the checks would not have been cashed.

ADMINISTRATIVE LAW JUDGE: Alright. Now at this point I'll stop and do you want to take over the questioning?

MR. KAUFMAN: Yes, I was lead to understand from Mr. Lutzak, that I would be able to tell my mother's story as opposed to the questioning of her. May I do that or am I in the wrong?

ADMINISTRATIVE LAW JUDGE: No, if you want to proceed in narrative fashion go right ahead.

MR. KAUFMAN: Thank you.

ADMINISTRATIVE LAW JUDGE: But are you going to testify here? If you are acting as her representative you may bring out the testimony through her.

MR. KAUFMAN: Okay.

ADMINISTRATIVE LAW JUDGE: By questioning, but if you are going to testify then I'll have to swear you in.

MR. KAUFMAN: Okay. I don't mind if you swear me in.

I'll just as soon be sworn in cause we may concurrently be giving information if thats at all possible.

ADMINISTRATIVE LAW JUDGE: Well, may I just ask before we get into that that what knowledge of the situation do you have that mother doesn't have?

MR. KAUFMAN: It's basically the same thing. I'm just trying to alleviate my mother's consternation at this point regarding this proceeding really. She may of course be able to bring out additional details, finer details that I might not know of. Basically, what it comes down to, we agree with all the facts up to date other than the one concerning that the point where difficulty occurred namely the asking of the person at Social Security whether she would be allowed to have her benefits continued after her remarriage. Now, being aware of the law as I am to the slight degree I am, I made my mother very aware of the situation and I was explicit with her to ask Social Security whether she would be entitled to the benefits or not. My mother did so and she had a conversation with the woman down there and reported back to me in a subsequent telephone call that everything was alright,

that she would be able to continue benefits but that they would be at a reduced rate.

(The representative Richard A. Kaufman, was duly sworn in, and testifies as follows:)

EXAMINATION BY ADMINISTRATIVE LAW JUDGE:

Q Who did your mother consult? What local offices of Social Security?

A I don't know the local office and she had no recollection of names whatsoever.

MRS. GOLDBERG: Flatbush Avenue.

MR. KAUFMAN: Flatbush Avenue.

ADMINISTRATIVE LAW JUDGE: Now, so it is apparent that the circumstances are today that somebody according to your testimony gave incorrect information. Now, because you know Mr. Kaufman due to your occupation, and so forth, there is no estoppel as such against the United States of America. Now the only bearing that this would have on the situation is whether or not in causing the overpayment your mother was at fault. And I'll certainly take that into consideration. Now that brings us one step further. If an individual is found not

to be at fault then the overpayment may be waived. However, it can only be waived under two subsequent conditions. One, is that the overpayment would defeat the purpose of Title II. So therefore, I have to ask certain questions and I don't care which one of you answers. I have to know what your income is? Per month? And what your basic expenses are?

MRS. GOLDBERG: What my husband's salary is now?

ADMINISTRATIVE LAW JUDGE: Yes.

MRS. GOLDBERG: Well he has a machine shop and this part year he drew in no more than \$4,000 through the complete year.

ADMINISTRATIVE LAW JUDGE: Now where is that machine shop located?

MRS. GOLDBERG: On McDonald Avenue and Courtelyou Road.

ADMINISTRATIVE LAW JUDGE: So he is self-employed.

MRS. GOLDBERG: Yes.

ADMINISTRATIVE LAW JUDGE: And you don't have by chance the income tax records with you?

MRS. GOLDBERG: No.

MR. KAUFMAN: That can be corrected.

ADMINISTRATIVE LAW JUDGE: But in any event total income reported from the business and total income from any source did not exceed \$4,000 is that right?

MRS. GOLDBERG: That's right.

MR. KAUFMAN: That included dividends and everything that he may have received from any source was that correct?

MRS. GOLDBERG: Maybe \$4,500. It was not over that. It was between \$4,000 and \$4,500. There was no money coming in.

ADMINISTRATIVE LAW JUDGE: Alright, now against that what expenses do you require?

MRS. GOLDBERG: Well, I'm at the doctors for a complete checkup, cardiogram and everything, at least \$75. to \$100. for every visit.

ADMINISTRATIVE LAW JUDGE: And how often is that?

MRS. GOLDBERG: For this past year it was twice, three times, twice to the hospital.

ADMINISTRATIVE LAW JUDGE: Is that compensated by any insurance policy of any kind?

MRS. GOLDBERG: No. None whatsoever.

ADMINISTRATIVE LAW JUDGE: Now, what do you pay rent?

MRS. GOLDBERG: \$172.00

ADMINISTRATIVE LAW JUDGE: And weekly food?

MRS. GOLDBERG: Approximately 50, 40-50.

ADMINISTRATIVE LAW JUDGE: What other expenses do you have?

MR. KAUFMAN: Other than drugs, basically drugs.

MRS. GOLDBERG: Basically drugs.

ADMINISTRATIVE LAW JUDGE: Drugs, how much is that per month?

MRS. GOLDBERG: The heart pills are very cheap. What can I say?

MR. KAUFMAN: Two, three, twenty, ten.

ADMINISTRATIVE LAW JUDGE: What do you take? Digitalis?

MRS. GOLDBERG: No, Isodol and Nitroglycerin. Isodol is 575 I get two. It's approximately \$15, \$18, a month.

ADMINISTRATIVE LAW JUDGE: Clothing, things of that nature. What do you estimate?

MRS. GOLDBERG: Well this year it has been nill.

ADMINISTRATIVE LAW JUDGE: Well entertainment, other miscellaneous items?

MR. KAUFMAN: That is probably included in food, I guess.

ADMINISTRATIVE LAW JUDGE: Alright. I'll tell you I'll give you to take with you so that you may do it at your leisure and with your son's help, a no fault questionnaire and we'll give you a franked envelope you can mail that back to us. But in order not to defeat the purpose of Title II the expenditures will have to outweigh the income.

MR. KAUFMAN: Hmmm.

ADMINISTRATIVE LAW JUDGE: Now is there anything else that you want to bring before me that I might, that's relevant to the issues that I might not have covered.

MR. KAUFMAN: Yes Judge. Simply that there is, while what I realize what the law says there is also a human factor involved, mainly that the marriage to my stepfather was only six weeks before my mother attended the age of 60. Now there was certainly no hurry involved and my mother and stepfather could have certainly waited that period of time if not longer if they were fully cognizent about these benefits, I expect. If my mother had known the benefits were going to cease if she

married before age 60 she certainly would have waited at least six weeks. Attendant to that is the fact that well it may really have no bearing that even one of the Social workers suggested that my mother have the marriage annulled to enable her to recollect the benefits and then remarry. It's just really an unfortunate thing that it even had to get to this stage but there was really no need to rush into the marriage. Really just the human interest aspect of it and at this stage it may or may not have any meaning. But so be it.

ADMINISTRATIVE LAW JUDGE: Well, of course I was cognizent of that reading the file--

MR. KAUFMAN: Do you want me to show you where it is?

ADMINISTRATIVE LAW JUDGE: But it doesn't lie within me to exercise any discretion.

MR. KAUFMAN: I understand.

ADMINISTRATIVE LAW JUDGE: Because there is no--on these provisions there is no flexibility.

MR. KAUFMAN: I understand.

ADMINISTRATIVE LAW JUDGE: It's like an insurance policy. It is an insurance policy.

MR. KAUFMAN: I understand.

ADMINISTRATIVE LAW JUDGE: Either you meet the provisions or you do not.

MR. KAUFMAN: Yes.

MRS. GOLDBERG: Had I been properly informed I would have met.

ADMINISTRATIVE LAW JUDGE: Well, I said the only bearing that will have on the case is whether or not I may waive the-- At this point waive the overpayment.

MR. KAUFMAN: Well I guess that's basically it.

ADMINISTRATIVE LAW JUDGE: I can't condone anybody who might have dispensed the wrong information. But on the other hand it doesn't change the situation in regard to the application.

MRS. GOLDBERG: Would that be fair and honest for me to get an annulment and then----

MR. KAUFMAN: It's unimportant, at this stage.

ADMINISTRATIVE LAW JUDGE: So, now if there is anything else. We will give you a no fault questionnaire. Mr. Lutzak will give that to you together with a franked envelope you mail

it in and I will withhold the decision on that part, until I receive that and I appreciate that you send it back because whatever steps are going to be taken and so forth I think should be taken rather quickly.

MR. KAUFMAN: Yes, let me ask you one further thing, Judge. I recollect that you mentioned before the exhibits that we looked at were selected out of the file. Were there any other pertinent exhibits that were not shown to me?

ADMINISTRATIVE LAW JUDGE: No, as a matter of fact whatever the balance of the file is here which consists--- you may see it if you want to--- put anything else to be an exhibit that the balance of the file.

MR. KAUFMAN: It's just financial information.

ADMINISTRATIVE LAW JUDGE: It's for the most part financial information, interoffice communication.

MR. KAUFMAN: Thank you.

ADMINISTRATIVE LAW JUDGE: Is there anything else?

MR. KAUFMAN: Just about the financials of my stepfather, if that's a necessary thing for us to furnish?

ADMINISTRATIVE LAW JUDGE: Well, it is because under

circumstances deduction overpayment may be waived if financial hardship is shown or a person in reliance on this change that position that another aspect which I have to consider.

MR. KAUFMAN: Is that part of the no fault that you are going to give me that request certain information to be filled out regarding that fact.

ADMINISTRATIVE LAW JUDGE: No. Already whatever you did on change of position is certainly very evident here, took a major step in life. Mother did remarry so in arriving at my decision I'll certainly consider that fact but this will only relate to the whether or not the recovery of that sum is in order and not to 202 provisions because under the law at the moment that's a fact and that what the section says that if you remarry. Now if this merely results in a reduction of benefits and it is deemed Congress thinks those things so thank heaven that the parties had not married after the age of 60. You see the intent on this Widow's Disability law is in a sense a "Johnny come lately" to the Social Security Act and was put in there to take care of a hiatus period in which the ordinary wife would face the children

growing up and leaving, becoming ill and unable to work during that period so Congress then put in Widow's Disability to take care of that time until she again at age 62 resume her other now age 60 resume her payments that would be coming to her as a wife and widow.

MR: KAUFMAN: Okay.

ADMINISTRATIVE LAW JUDGE: Alright. So now we have nothing further we will close the hearing. Mr. Kaufman I have reopened the hearing at this point and I have now submitted to you and to your mother a no fault questionnaire and refund statement. Now as I udnerstand you are to return it to me in the franked envelope provided. Do you agree at this time upon reception of those in the office, they will be admitted into the record as Exhibit 23.

MR. KAUFMAN: Yes

ADMINISTRATIVE LAW JUDGE: Alright, thank you.

(The hearing closed at 10:42 a.m.)

C E R T I F I C A T I O N

I have read the foregoing and hereby certify that it is a true and complete transcription of the claimant's testimony, at the hearing held in the above case before Administrative Law Judge, Thomas A. Powell.

Barbara O'Connor
BARBARA O'CONNOR
SECRETARY

APPLICATION FOR WIDOW'S INSURANCE BENEFITS*

If you are applying as a widow, the information you furnish on this application will ordinarily be sufficient for a determination on the lump-sum death payment, without the filing of a separate application. If you are awarded monthly benefits on this application and such benefits continue to age 65, you will be automatically entitled to hospital insurance protection at age 65. In addition, this application form may be used for enrollment in the Supplementary Medical Insurance Benefits plan.

Form approved.
Budget Bureau No. 72-R0114

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NOTICE: Whoever makes or causes to be made any false statement or representation of a material fact in an application or for use in determining a right to payment under the Social Security Act is subject to not more than a \$1,000 fine or 1 year of imprisonment, or both.

Enter Name of Deceased Wage Earner or Self-Employed Person.

Enter Your Full Name.

Enter His Social Security Number.

Enter Your Social Security Number
(If none or unknown, so indicate)

I hereby apply for entitlement to all insurance benefits which may be payable under Title II and Part A of Title XVIII of the Social Security Act, as amended.

1. (a) Have you ever before filed an application with the Social Security Administration for monthly benefits or for hospital or medical insurance?
☐ Yes (If "Yes," answer (b) and (c).)

☒ No (If "No," go on to Question 2.)

(b) Enter name of person on whose earnings record you filed other application(s).

(c) Enter Social Security number of person named in (b).
(If unknown, so indicate.)

PART I — INFORMATION ABOUT DECEASED WORKER

2. Enter the date of birth of the deceased (Month, Day and Year)

3. Enter the date and place of death.
(Month, Day and Year)

4. Enter the name of the state or foreign country where the deceased had his fixed permanent home at the time of his death.

STATE OR FOREIGN COUNTRY

5. Enter the names and addresses of all the persons, companies or government agencies for whom the deceased worked during the 12 months before death. (If none, write "None".)
If the deceased worked in agricultural employment, give this information for the year of death and the year before.

NAME AND ADDRESS OF EMPLOYER
If deceased had more than one employer, please list them in order beginning with last (most recent) employer.

WORK BEGAN

WORK ENDED

MONTH

YEAR

MONTH

YEAR

(Use "Remarks" space for information about any other employer.)

6. (a) Was the deceased self-employed this year, last year, or the year before?
☐ Yes (If "Yes," answer (b).)

☒ No (If "No," go on to question (7).)

(b) Check the year or years in which the deceased was self-employed.

In what kind of trade or business was the deceased self-employed?

Were the deceased's net earnings from his trade or business \$400 or more?
(Check "Yes" or "No")

☐ This Year

☐ Last Year

☐ Year Before Last

☐ Yes ☐ No

☐ Yes ☐ No

☐ Yes ☐ No

7. (a) About how much did the deceased earn from employment and self employment during the year in which he died?

If death occurred this year, answer (b). If not, go on to item 8.

(b) About how much did the deceased earn last year?

AMOUNT

\$

AMOUNT

\$

ABT 1,000.00

Exhibit No.

Over 7800.00

8. Did the deceased work in the railroad industry at any time on or after January 1, 1937? ☐ Yes ☒ No

9. (a) Was the deceased in active military or naval service after September 7, 1939? ☐ Yes ☒ No
 If "Yes," answer (b) and (c). If "No," go on to item 10.

(b) Enter name of branch (Army, Navy, etc.), country served (if other than U.S.) and dates of service.

(c) Has anyone (including the deceased) received, or does anyone expect to receive, from any Federal agency other than the Social Security Administration, a benefit based on the employment, military service, disability, or death of the deceased?
 If "Yes," enter name(s) of such person(s) and name(s) of Federal agency(ies). ☐ Yes ☐ No

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PART II — MARRIAGE AND RELATED INFORMATION

10. Enter below the information requested about each marriage of the deceased, including his marriage to you.

LAST MARRIAGE OF THE DECEASED	TO WHOM MARRIED	WHEN (Month, Day, and Year)	WHERE (Enter name of City and State)
	HOW MARRIAGE ENDED		
PREVIOUS MARRIAGE OF THE DECEASED	TO WHOM MARRIED	WHEN (Month, Day, and Year)	WHERE (Enter name of City and State)
	HOW MARRIAGE ENDED		

(Use "Remarks" space for information about any other marriage.)

11. Check ☒ whether your marriage to the deceased was performed by:
 Clergyman ☒ Authorized public official ☐ Other ☐ (Explain)

12. Have you married since the death of the deceased? ☐ Yes ☒ No

13. Enter below the information requested about each of your marriages. Indicate your marriage to the deceased by entering his name; it is not necessary to repeat the other information about this marriage you have already given in item 10. Enter complete information on all other marriages, whether before or after you married the deceased.

YOUR LAST MARRIAGE	TO WHOM MARRIED	WHEN (Month, Day, and Year)	WHERE (Enter name of City and State)
	HOW MARRIAGE ENDED		
YOUR PREVIOUS MARRIAGE	TO WHOM MARRIED	WHEN (Month, Day, and Year)	WHERE (Enter name of City and State)
	HOW MARRIAGE ENDED		

(Use "Remarks" space for information about any other marriage.)

14. Answer question 14 only if you are the widow.

(a) Were you and the deceased living together at the same address when the deceased died? ☒ Yes ☐ No

(b) If either the deceased or you were away from home (whether or not temporarily) when the deceased died, give the following:

WHICH WAS AWAY ☐ DECEASED ☐ SURVIVING SPOUSE DATE LAST HOME

REASON ABSENCE BEGAN REASON YOU WERE APART AT TIME OF DEATH

IF HOSPITALIZED, ENTER NAME OF HOSPITAL AND NATURE OF ILLNESS OR DISABLING CONDITION.

15. Answer question 15 only if you were divorced from the deceased.

(a) Was the deceased under a court order to contribute to your support? ☐ Yes ☐ No

(b) Was the deceased contributing to your support? ☐ Yes ☐ No

PART III — INFORMATION ABOUT YOURSELF

16. Enter your date of birth (Show month, day, and year). 7 / 15 / 1912 Enter the name of the State or foreign country where you were born. BOSTON MASS 40

17. Enter your maiden name. JOHN D. M. T. H.

18. (a) Are you unable to work because of a disabling condition?
☒ Yes (If "Yes," answer (b).) ☐ No (If "No," go on to item 19.)

(b) Enter date on which your disabling condition began. 1965 MONTH, DAY, YEAR

If you are age 62 or older, or you will reach age 62 in this month or one of the next 3 months, answer Questions 19 and 20. If not, go on to Item 21.

19. Were you in active military or naval service after September 7, 1939? ☐ Yes ☒ No

20. Did you work in the railroad industry at any time on or after January 1, 1937? ☐ Yes ☒ No

If you are filing ONLY as a disabled widow, omit items 21, 22, 23, 24, and go on to item 25. In all other cases, items 21, 22, 23 and 24 must be answered.

Please read the following information before going on to Item 21.

Some or all of your benefits are not payable if, while under 72, you work for more than the monthly limit in employment (as defined below) or perform substantial services in self-employment in any month, and have earnings in excess of the exempt amount (as defined below) for the taxable year.* This applies to all employment and self-employment, whether or not covered by the Social Security Act.

The monthly limit is \$125 per month for months in a taxable year ending prior to 1968 and \$140 per month for any taxable year ending after 1967. If the taxable year is a calendar year, the \$140 amount is effective January 1968.

The exempt amount of total earnings which a beneficiary may have without deduction from benefits is \$1,500 per year for a taxable year which ends before 1968. It is \$1,680 per year for taxable years ending after 1967. If the taxable year is a calendar year, \$1,680 is the exempt amount beginning 1968.

As an employee, you count the gross wages (not the take-home pay) you earn during the year, regardless of when the wages are paid to you. As a self-employed person, you count the net earnings from your business (after deducting allowable business expenses).

21. Answer item 21 only if the deceased died before this year.

(a) How much were your total earnings last year?
 If the total in (a) is over the exempt amount, answer (b). If less, omit (b) and (c) and go on to item 22. \$ none

(b) Did you earn more than the monthly limit in employment or perform substantial services in self-employment in each month of last year?
☐ Yes (If "Yes," omit (c).) ☐ No (If "No," answer (c).)

(c) Circle each month of last year in which you did not earn more than the monthly limit in employment and did not perform substantial services in self-employment.

Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

22. (a) How much do you expect your total earnings to be this year? (Count all earnings beginning with the first of this year and all anticipated earnings through the end of this year.) \$ none

If the total in (a) is over the exempt amount, answer (b). If less, omit (b) and (c).

(b) Have you earned more than the monthly limit in employment or performed substantial services in self-employment in each of the months of this year including the present month?
☐ Yes (If "Yes," omit (c).) ☐ No (If "No," answer (c).)

(c) Circle each month of this year in which you did not earn more than the monthly limit in employment and did not perform services in self-employment.

Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

An annual report of earnings must be filed with the Social Security Administration within 3 months and 15 days after the end of any year in which you earned more than the exempt amount, if you were under age

72 at least one full month of that year and received some benefit payment for such a month. FAILURE TO REPORT MAY RESULT IN THE LOSS OF ADDITIONAL MONTHLY BENEFITS.

23. Do you agree to file the annual report of earnings when required?

☒ Yes ☐ No

*The yearly period referred to in this and following items is the same 12-month period you use in figuring your income tax. If you use a fiscal year, that is, a taxable year that does not end Dec. 31 (with income tax return due April 15), enter here the month your fiscal year ends.

MONTH

(OVER)

24. This application for widow's benefits may be retro-active for as many as 12 months from the date it is filed but not for any month before you reached age 60. If you are under age 63, your application may be for widow's benefits payable at a reduced rate. They

will continue at a reduced rate even after you reach age 62. If there are any months before you reach age 62 for which you do not wish to claim benefits enter the months here and give your reason.

41

Notify the Social Security Administration promptly if you remarry. Generally, remarriage will terminate or decrease the amount of the widow's benefit to which you are entitled. Certain exceptions to this general rule are explained in the "Rights and Responsibilities" booklet which you will receive. However, you must report even if you believe an exception applies. The Social Security Administration will advise you what

additional information and evidence, if any, is needed and will give you a decision on whether your benefits may continue in the regular amount. If the man you marry is entitled to social security benefits, the Social Security Administration will advise you whether you can receive a higher benefit based on his earnings record.

25. Do you agree to notify the Social Security Administration promptly if you remarry, and to promptly return any benefit check you receive for the month you remarry, and for any later month?

REMARKS (You may use this space for any explanations. If you need more space, attach a separate sheet.)

☒ Yes

☐ No

Knowing that anyone making a false statement or representation of a material fact in an application or for use in determining a right to payment under the Social Security Act, commits a crime punishable under Federal law, I certify that the above statements are true.

If this application (and, if relevant, the enrollment question below) has been signed by mark (X), two witnesses who know the applicant must sign below, giving their full addresses.

1. NAME

SIGNATURE (Write in Ink)

SIGN
HERE

ADDRESS (Number and Street, City, State, and ZIP Code)

MAILING ADDRESS (Number and Street, P.O. Box, or Rural Route)

2. NAME

CITY AND STATE

ZIP CODE

ADDRESS (Number and Street, City, State, and ZIP Code)

DATE (Month, Day and Year)

TELEPHONE NUMBER

ENTER NAME OF COUNTY (if any) IN WHICH YOU NOW LIVE

Answer the question below only if you are now AGE 65 or over, or you will reach AGE 65 in this month or one of the next three months.

ENROLLMENT IN THE SUPPLEMENTARY MEDICAL INSURANCE BENEFITS PLAN

Your social security district office will be glad to explain this plan and to give you a leaflet containing information on the physicians' and surgeons' services and other medical services covered, premium amounts, enrollment periods, etc. A request for enrollment cannot be effective unless it is made within one of the enrollment periods specified in the law. If you do not enroll within your initial enrollment period, you may have to pay a higher premium and your coverage will be delayed.

Do you wish to enroll in the supplementary medical insurance benefits plan? (Premium payments will be due. Where possible, these payments will be deducted from your monthly benefit check.)

☐ Yes

☐ No

☐ Undecided

☐ Currently Enrolled

Sign below regarding medical insurance benefits plan.

SIGN
HERE

Form SS-5
TREASURY DEPARTMENT
INTERNAL REVENUE SERVICE

U. S. SOCIAL SECURITY ACT
APPLICATION FOR ACCOUNT NUMBER

065-01-5460

1. MURRY (EMPLOYEE'S FIRST NAME) David (MIDDLE NAME) KAUFMAN (LAST NAME) 155

2. 1 Ave K (STREET AND NUMBER) (MARRIED WOMEN: GIVE MAIDEN FIRST NAME, MAIDEN LAST NAME, AND HUSBAND'S LAST NAME)

3. BROOKLYN (POST OFFICE) N.Y. (STATE)

4. Well & HARTMAN (BUSINESS NAME OF PRESENT EMPLOYER) 5. 128 West 31 St. (BUSINESS ADDRESS OF PRESENT EMPLOYER)

6. 25 (AGE AT LAST BIRTHDAY) 7. 12 - 12 - 1910 (DATE OF BIRTH: (MONTH) (DAY) (YEAR) (SUBJECT TO LATER VERIFICATION))

8. New York (PLACE OF BIRTH)

9. MAX KAUFMAN (FATHER'S FULL NAME) 10. DORA DAVIS K (MOTHER'S FULL MAIDEN NAME)

11. ☒ MALE ☐ FEMALE (CHECK (X) WHICH) 12. COLOR: ☒ WHITE ☐ NEGRO ☐ OTHER (CHECK (X) WHICH) (SPECIFY) 1 - 1

13. IF REGISTERED WITH THE U. S. EMPLOYMENT SERVICE, GIVE NUMBER OF REGISTRATION CARD _____

14. IF YOU HAVE PREVIOUSLY FILLED OUT A CARD LIKE THIS, STATE _____

15. 12/36 (DATE SIGNED) 16. Murry Kaufman (EMPLOYEE'S SIGNATURE, AS USUALLY WRITTEN) (PLACE) (DATE)

DETACH ALONG THIS LINE

Exhibit No. 2



STATEMENT REGARDING DISABILITY
(BY WIDOW, WIDOWER, SURVIVING DIVORCED WIFE, OR CHILD)

CHRISTENSEN 43

Form Approved
Budget Bureau No. 72-10011
13 (Do not write in this space)

MAR 10

NOTICE—Whoever makes or causes to be made any false statement of representation of a material fact in an application or for use in determining a right to payment under the Social Security Act is subject to not more than a \$1,000 fine or 1 year of imprisonment or both.

1. Enter name of wage earner or self-employed person

Enter His Social Security Number

MURRAY KAUFMAN

CG 57 01 54 66

This statement is filed in connection with a claim for benefits by a disabled person, i.e., widow, widower or child age 18 or over. (If you are the disabled person, answer the questions on this form with respect to yourself.)

2. Enter Full Name of Disabled Person

Enter date of birth of the disabled person
(Show month, day and year)

LILLIAN KAUFMAN

7 | 15 | 1912

3. (a) Has the disabled person ever had a social security number of his own?

☒ Yes (If "Yes," complete (b).) ☐ No (If "No," go on to item 4.)

(b) Enter the disabled person's social security number here

Social Security Number (If unknown, so indicate)

0613419246

Answer Question 4 only if the disabled person is applying for widow's or widower's benefits.

4. (a) Was the disabled widow or widower previously entitled to monthly benefits on the account of the person named in item 1?

☐ Yes (If "Yes," complete (b).) ☒ No (If "No," go on to item 5)

(b) Enter date benefits ended (or will end)

Month and Year

5. What is the disabled person's disability? (Briefly describe the injury or illness that has prevented the disabled person from working.)

6. Check the first block which applies to the disabled person.

(a) ☐ Confined in a medical institution other than a general hospital

(d) ☐ Confined in a chair (Including wheel chair)

(b) ☐ Patient in a general hospital

(e) ☐ None of the above but unable to go outside

(c) ☐ Confined in bed at home

(f) ☐ Able to go outside but only with help of another person or device

(g) ☒ Able to go outside without help

7. Enter the date on which the disabling condition began.

Date (Month, day, year)

1965 over
[Signature]

8. Do you authorize any physician, hospital, agency, or other organization to disclose to the Social Security Administration or to the State agency that may review the disabled person's claim or continuing disability, any medical records or other information about the disabled person's disability?

☒ Yes

☐ No

44

The events listed below may affect the disabled person's entitlement to benefits. You will find a more complete explanation of what events apply to the disabled person, and how they affect benefits, in the "Rights and Responsibilities" booklet you will receive.

Report the following events:

(a) The disabled person's MEDICAL CONDITION IMPROVES so that he would be able to work, even though he has not yet started to work;

(b) The disabled person GOES TO WORK whether as an employee or a self-employed person;

If the disabled person is now hospitalized, —

(c) The disabled person is DISCHARGED FROM THE HOSPITAL.

9. Do you agree to notify the Social Security Administration promptly if any of the above events occur?

☒ Yes

☐ No

Remarks: (This space may be used for explaining any answers to the questions. If additional space is required, attach a separate sheet.)

IMPORTANT INFORMATION. PLEASE READ CAREFULLY. — An applicant for widow's, widower's or child's insurance benefits as a disabled person is required to submit medical evidence showing the nature and extent of the disability during the time he (she) is alleged to be under a disability. If such evidence is not sufficient to arrive at a determination, the

disabled person may be requested to have an independent medical examination at the expense of the Social Security Administration. Should the Social Security Administration obtain information useful to his physician for treatment, such information may be furnished to the physician upon his request and with consent of the source.

Knowing that anyone making a false statement or representation for use in determining a right to payment under the Social Security Act, commits a crime punishable under Federal law, I certify that the above statements are true.

If this statement has been signed by mark (X), two witnesses who know the person making the statement must sign below, giving their full addresses.

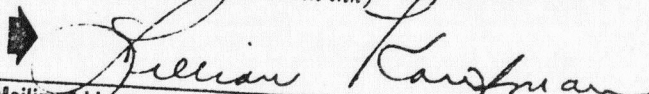
1. Name

Address (Number and Street, City State and ZIP Code)

2. Name

Address (Number and Street, City State and ZIP Code)

Signature of Applicant (Write in ink)


Mailing Address (Number and Street, P.O. Box, or Route)

1225 OCEAN PARKWAY
City and State Zip Code

BROOKLYN, N.Y. 11220

Date (Month, Day, and Year) Telephone Number
3/10/69 DES 6907

Enter Name of County (if any) in Which You Now Live
KINGS

TABLE 1

STATEMENT OF DEATH BY FUNERAL DIRECTOR

NOTICE.—Whoever makes or causes to be made any false statement or representation of a material fact for use in determining a right to payment under the Social Security Act is subject to not more than a \$1,000 fine or 1 year of imprisonment, or both.

1. NAME OF DECEASED
MURRAY KAUFMAN

2. SOCIAL SECURITY ACCOUNT NUMBER
065-01-5460

3. SEX
☒ MALE ☐ FEMALE

4. DATE OF DEATH OF DECEASED
2-12-69

5. NAME AND ADDRESS OF DECEASED'S NEXT OF KIN. (IF NO RELATIVE'S ADDRESS IS KNOWN, STATE NAME AND ADDRESS OF PERSON WHO ARRANGED FOR BURIAL.)

NAME OF NEXT OF KIN
LILLIAN KAUFMAN 3 weeks

RELATIONSHIP
WIFE

ADDRESS (No. and Street, P.O. Box)
1225 OCEAN PKWAY.

CITY AND STATE
BROOKLYN, N.Y.

TELEPHONE NUMBER OF NEXT OF KIN (If available)
DE 8-6907

I hereby certify that I am an authorized funeral director and prepared for burial or buried the body of the person named above. I understand this statement may be used in connection with an application for social security benefits.

NAME OF FUNERAL DIRECTOR OR FIRM
RIVERSIDE MEM. CHAPEL, INC.

ADDRESS (No. and Street, P.O. Box)
310 CONEY ISLAND AVENUE

CITY, STATE, AND ZIP CODE
BROOKLYN, NEW YORK 11210

SIGNATURE OF FUNERAL DIRECTOR OR AUTHORIZED REPRESENTATIVE OF FIRM
George J. Smith

TITLE
Funeral Director

TELEPHONE NUMBER
444-2000

DATE
2-14-69

FORM SSA-721 (9-67)

Exhibit No. 4

* GPO : 1966 O - 239-205

PLEASE TYPE OR PRINT CLEARLY

DISABILITY DETERMINATION AND TRANSMITTAL

FORM APPROVED 41
BUDGET BUREAU 72K523.5
2. DATE APP'D

03/10/69

3. W/E (If Auxiliary Filing)

Murray Kaufman

5. NAME AND ADDRESS OF CLAIMANT

Lillian Kaufman
1225 Ocean Pky
Brooklyn NY 11230

1. FOLDER TO

BDI ☐ SA ☒ DFC ☐

4. SOCIAL SECURITY ACCOUNT NUMBER
065-01-5460

OASI
W/E ☒

DB
W/E ☐

6. DB
07/15/12

7. SEX
M ☒ F ☐

8. RACE
W ☒ N ☐ O ☐

9. AOD
XX/XX/65

10. AGE
53

11. CLAIM FOR

FREEZE ☐ DIB ☐ CHILD ☐ DWB ☒

12. FAMILY STATUS

MAR ☐ SO ☒ NO. CHILDREN (UNDER 18) none

13. OC REQ. LAST MET

14. ☐ W/E DOES NOT MEET 20/40 REQ

A. ☐ DIS. BDI REVIEW

B. ☐ SINCE LAST DET

18. SA CODE

330

19. STATE

New York

15. PREV. DENIED OR TERM.

20. DISTRICT OFFICE ADDRESS
135 E 22 St
Brooklyn NY 11226

16. NON-DIS. DEV. IN PROGRESS

17. MED. DEV. DEF

DO CODE

127

RO CODE

21

FILE REVIEWED & APPROVED FOR TRANSMITTAL

21. CLAIMS REPRESENTATIVE

22. DATE OF TRANSMITTAL

PURSUANT TO PROVISIONS OF SEC. 221 OF SOCIAL SECURITY ACT, IT IS DETERMINED THAT THE CLAIMANT:
Prescribed period begins 02/69 and ends 06/72

24. ☒ HAS BEEN UNDER A DISAB. SINCE

10-1-68

25. ☐ WAS UNDER A DISAB.

A. DATE FROM B. TO

26. ☐ WAS NOT UNDER A DISAB. ON OR BEFORE (Date)

29. DIAGNOSIS

ASHD MT LBBB

27. ☐ WAS NOT UNDER A DISAB.

28. CASE OF BLINDNESS AS DEFINED IN SEC 216(1)

A. ☐ NOT UNDER A DISAB FOR CASH BENE PURP

B. ☐ UNDER A DISAB FOR CASH BENE PURP SINCE

31. VOCATIONAL BACKGROUND (Occupation)

32. BASIS FOR DETERMINATION

1502 (a) 1

LISTING

4.06 F

30. MOF CODE

OCC. YEARS

EDUC. YEARS

12

CONTINUED ON ATTACHED SHEET (Use OA-D834)

33. RECOMMEND RE-EXAM ON (Date)

34. DISABILITY EXAMINER SA

M. Pucellato 5/1/69

35. REVIEW PHYSICIAN SA

J. J. J.

37. DATE
5/5/69

38. ☐ CHILD'S DISABILITY BEGAN BEFORE AGE 18 AND CONTINUES

☐ CHILD NOT UNDER A DISABILITY WHICH BEGAN BEFORE AGE 18

39. ☐ W/E MEETS 20/40 TEST IN

☐ W/E DOES NOT MEET 20/40 TEST, HAS OF 40 QTR. ENDING

40. PERIOD OF DISABILITY IS

☒ ESTABLISHED FROM 10/01/68 TO CONT.

☐ NOT ESTABLISHED

41. REMARKS
WIDOW'S AN 061-34-9246.

42. RE-EXAM REQ

NONE

43. DISABILITY EXAMINER

44. DATE

45. DISABILITY EXAMINER

L. J. J. - 3

46. DATE
05/21/69

CLAIMANT TO BE NOTIFIED BY

47. ☐ BDI

☒ PC

48. LTR/PAR NO

49. PRIOR ACT

☐ PD ☐ PT

☐ REVISED

50. BASIS CODE

1

51. A OR D CODE

A-1

52. RETURN CODE

53. CAT.

W

☐ DIB ☐ OSF

☐ CH ☐ FB

☐ VAD

54. SPECIAL CODE

☐ VA

☐ VAD

55. LIST NO.

FORM OA-D831 (1-68)

1-FOLDER COPY

Exhibit No. 5

CONTINUATION SHEET
FOR DISABILITY DETERMINATION

MB:LFUSM

48

NOTE. --- Use this form only when necessary for continuation of Item 32 of "DISABILITY DETERMINATION" or Item 3 of "CESSATION OR CONTINUANCE OF DISABILITY".

NAME Lillian Kaufman (DWB)	NAME OF WAGE EARNER (IF DISABLED CHILD FILING) Murray Kaufman (DWB)	SOCIAL SECURITY ACCOUNT NO. 065-01-5460	DATE 5/1/69
-------------------------------	--	--	----------------

Widow alleges onset of 1965 due to a heart condition.

The medical evidence indicates that a severe heart disease was first discovered during her hospitalization in 10/68.

In 11/68, she came under the care of her current attending physician. Onset can reasonably be set as of 10/1/68.

TO NYPC -

NYPC JUL 27 1972

49



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

RECONSIDERATION

Form Approved
Budget Bureau No. 72-80552

NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON <u>Murray Kaufman</u>		SOCIAL SECURITY CLAIM NUMBER <u>065-01-5460W</u>	BR <u>13</u>	(Do not write in this space) <u>1225 St.</u>
NAME OF CLAIMANT <u>Lillian Kaufman</u>				JUL 26 1972
CLAIM FOR (Specify type, e.g., retirement, disability, hospital insurance, etc.) <u>Reinstatement of disabled widows benefits</u>				21127
			SSA	DISTRICT OFFICE

I do not agree with the determination made on the above claim and request reconsideration.

My reasons are: I was 60 in July. I remarried in May & my benefits were terminated. I was told by one of your employees that if I remarry my benefits would continue at a lesser amount. Nothing was

NOTE: If the date of the notice of the determination on this claim was more than six months ago include your reason for not making this request earlier.

I am submitting the following additional evidence (If none, write "None."):

said about my age.

SIGNATURE OF WITNESSES ONLY		SIGNATURE (Write in Ink—First, Middle Initial, Last Name)	
If this request has been signed by mark (X), two witnesses who know the person requesting reconsideration must sign below, giving their full addresses.		<u>Lillian Kaufman</u>	
1. NAME	ADDRESS (Number and Street, City, State and Zip Code)	MAILING ADDRESS (Number and Street, P.O. Box or Route)	
2. NAME	ADDRESS (Number and Street, City, State and Zip Code)	<u>1225 Ocean PKwy</u>	
		CITY AND STATE <u>BKLYN NY</u>	ZIP CODE <u>11230</u>
		DATE (Month, Day, and Year) <u>7/26/72</u>	TELEPHONE NUMBER <u>De 8-6907</u>
FOR SOCIAL SECURITY OFFICE USE ONLY			
PROVIDER NAME AND NUMBER	INTERMEDIARY NAME AND NUMBER	SOCIAL SECURITY OFFICE ADDRESS	
ROUTING INSTRUCTIONS (Check one)			
<input type="checkbox"/> State Agency (Route with disability folder)		<input type="checkbox"/> Division of Foreign Claims, Balto.	
<input type="checkbox"/> Payment Center _____ BDI, Balto. <input type="checkbox"/>		<input type="checkbox"/> BDPA, Attn: CWAB, Balto.	
<input type="checkbox"/> BHI, RO _____ <input type="checkbox"/> BHI, Attn: DRB, Balto.		<input type="checkbox"/> Intermediary	

FORM SSA-561 (8-68)

NOTE: Take or mail completed copies to your Social Security Office.

Exhibit No. 6 (p100pp)



NOTICE OF SUSPENSION OR TERMINATION OF BENEFITS

50

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

SOCIAL SECURITY ADMINISTRATION

PAYMENT CENTER

FLUSHING, NEW YORK 11348

REFER TO CLAIM NUMBER

065- 01-5460 W

DATE:

July 14 1972

BUREAU OF RETIREMENT
AND SURVIVORS INSURANCE

Lillian Kaufman
1225 Ocean Pky
Brooklyn NY 11230

Cons. of

For children of

For

As gdn. of

Beginning with May 1972

indicated below. Any check received for this month, or later months, should be returned to the Treasury Department, Bureau of Accounts, Division of Disbursement, as shown on the check envelope. Social security benefit checks are normally dated the third of the month following the month for which they are payable. If the check(s) has been cashed please make repayment in the amount of the check(s).

- ☒ Our records indicate you have been overpaid \$265.00. If the check(s) covering this amount has not been cashed, please return it to the Treasury Department as shown above. If the check(s) has been cashed, make the refund payable to the Social Security Administration. Always include your claim number as indicated above on the check or money order.

☐ Death of beneficiary

Note: All of the beneficiary's unused benefits (plus accrued interest) belong to his estate and should be remitted to the legal representative, or disposed of in accordance with state law, if there is no legal representative.

Caution: This instruction does not apply to uncashed checks, they should be returned as indicated above, if the check is for a month prior to death, get in touch with any social security office as the check may be reissued.

- ☐ Failure to have a child entitled to benefits in your care
Note: If the child returns to your care or you attain age 62 (or age 60 if you are then a widow; or age 50 if then disabled and a widow). Get in touch with any social security office as you may be entitled to further benefits.

☐ Adoption☐ Death Marriage of Child

Note: Get in touch with any social security office at age 62 (or age 60 if you are then a widow; or age 50 if then disabled and a widow) as you may be entitled to further benefits.

☐ Adoption of child

Note: Get in touch with any social security office at age 62 (or age 60 if you are then a widow; or age 50 if then disabled and a widow) as you may be entitled to further benefits.

☐ Child attained age 18 and not disabled

Note: Get in touch with any social security office at age 62 (or age 60 if you are then a widow; or age 50 if then disabled and a widow) as you may be entitled to further benefits.

☐ No Longer Full Time Student

Note: If full-time school attendance is resumed and the student has not attained age 22, get in touch with any social security office as benefits may again be payable.

☐ Attained age 18 or 22 and not receiving benefits because of a disability

Note: Get in touch with any social security office if the child is disabled as further benefits may be payable.

☐ OtherExhibit No. 6

Over

(P2 of 2 pp) 2
FORM SSA-597 (10-71)

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

51

RECONSIDERATION DETERMINATION

PAYMENT CENTER Office of the Regional Representative (Retirement and Survivors) New York		DISTRICT OFFICE 135 East 22 Street Brooklyn, New York 11226
NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON Murray Kaufman		SOCIAL SECURITY ACCOUNT NO. 065-01-5460
NAME OF CLAIMANT Lillian Goldberg		TYPE OF CLAIM Disabled Widow's Insurance Benefits
DETERMINATION:		

Murray Kaufman died February 12, 1969. Lillian Kaufman, who was born July 15, 1912, filed an application for disabled widow's insurance benefits on March 10, 1969 and was entitled to these benefits effective April 1969. Her entitlement to disabled widow's insurance benefits terminated May 1972 based on her report of remarriage on May 21, 1972. A notice of this termination was sent to her on July 14, 1972. Lillian Goldberg (Kaufman) filed a request for reconsideration on July 26, 1972. She affirmed that she remarried in May 1972 and attained age 60 in July 1972. However, she stated she had been informed by an employee of the Social Security Administration that if she remarried her benefits would continue at a lesser amount, but nothing was said about her age at the time of remarriage.

The issue to be decided is whether Lillian Goldberg is entitled to disabled widow's insurance benefits on the account of Murray Kaufman beginning May 1972.

Section 202(e)(1) of the Social Security Act, as pertains to this case, provides for the payment of widow's benefits to a qualified widow of an individual who died fully insured and attained age 50, but has not attained age 60 and is under a disability which began before the end of a period prescribed by the Act. Entitlement ends with the month preceding the first month in which the widow remarries before attaining age 60, unless her remarriage is to a person who is entitled to widower's, parent's or disabled child's insurance benefits.

Section 202(e)(4) of the Social Security Act provides that a widow's entitlement to widow's insurance benefits is not terminated by reason of her remarriage after attaining age 60. However, if the marriage is to a man not entitled to widower's, parent's, or disabled child's insurance benefits, the amount of the widow's insurance benefit is reduced from 82 1/2 percent to 50 percent of the primary insurance amount, beginning with the month in which such marriage occurred.

Murray Kaufman

065-01-5460

2

The evidence in file establishes that Mrs. Goldberg remarried before age 60 to a man who is currently working and who has never been entitled to any social security benefits. As prescribed by law her entitlement to disabled widow's insurance benefits terminated May 1972.

Upon reconsideration, the determination that Lillian Goldberg is not entitled to disabled widow's insurance benefits on the account of Murray Kaufman beginning May 1972, is affirmed.

Bernard Levine
Chief, Reconsideration Branch

November 7, 1972



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
Bureau of Retirement and Survivors Insurance

53

New York, New York

When writing about your claim
always give Claim No.

065-01-5460

November 7, 1972

Mrs. Lillian Goldberg
1225 Ocean Parkway
Brooklyn, N. Y. 11230

Dear Mrs. Goldberg:

As you requested, your claim has been reconsidered. It has been found that the original decision was correct and in accordance with the law and regulations. The enclosed Reconsideration Determination fully explains the decision reached.

This reconsideration was made by a member of a specially designated staff, different from the staff that made the original decision, and specially trained in the handling of reconsiderations. This staff made an independent and thorough examination of all the evidence on record about your claim.

If you believe that the Reconsideration Determination is not correct, you may request a hearing before a hearing examiner of the Bureau of Hearings and Appeals. If you want a hearing you must request it not later than 6 months from the date of this notice. You should make any such request through your social security office. Please read the enclosed leaflet for a full explanation of your right to appeal.

Sincerely yours,

Rosquale J. Caligiuri

Regional Representative
Retirement and Survivors Insurance

Enclosures:
Form OA-C662
Form BHA-1

Exhibit No. 8

EARNINGS CERTIFICATION - P.I.A. DETERMINATION

ACCOUNT IDENTIFICATION				PERTINENT DATES				BOPA CAUTION SIGNALS				BLOCK NUMBER			
ACCOUNT NUMBER	NAME	DATE OF BIRTH	DATE OF DEATH	FILING	MO	DAY	YEAR	MO	DAY	YEAR	MO	DAY	YEAR	TYPE ACTION	
065 01 560	KAUFMA	12 25 10												1439583 S	
MILITARY SERVICE DATES				WORK DED AND SUSPENSION INFORMATION				BENEFIT COMPUTATIONS				SUR			
FROM TO				YR. AMOUNT				TYPE FIRST BASE YR OR SD				SUR			
1951 1969				67200.00				TYPE FIRST BASE YR OR SD				SUR			
NS 65				51-68 156				TYPE FIRST BASE YR OR SD				SUR			
RED MOS				REDUCED BENEFITS				TYPE FIRST BASE YR OR SD				SUR			
160.50				160.50				TYPE FIRST BASE YR OR SD				SUR			
EARNINGS RECORD DATA				OC AND EARNINGS TOTALS				CORRECTIONS IN BLOCKS 3 AND 6				DO. PC OR BDI REMARKS			
REQUIRED OC	MAX	FIRST	LAST	MAX	TEST	TEST	TEST	TEST	TEST	TEST	TEST	TEST	TEST	TEST	
18	47	47	47	47	47	47	47	47	47	47	47	47	47	47	
37	48	48	48	48	48	48	48	48	48	48	48	48	48	48	
38	49	49	49	49	49	49	49	49	49	49	49	49	49	49	
39	50	50	50	50	50	50	50	50	50	50	50	50	50	50	
40	51	51	51	51	51	51	51	51	51	51	51	51	51	51	
41	52	52	52	52	52	52	52	52	52	52	52	52	52	52	
42	53	53	53	53	53	53	53	53	53	53	53	53	53	53	
43	54	54	54	54	54	54	54	54	54	54	54	54	54	54	
44	55	55	55	55	55	55	55	55	55	55	55	55	55	55	
45	56	56	56	56	56	56	56	56	56	56	56	56	56	56	
46	57	57	57	57	57	57	57	57	57	57	57	57	57	57	
47	58	58	58	58	58	58	58	58	58	58	58	58	58	58	
AUXILIARY OR SURVIVOR BENEFIT DATA				RELATIONSHIP				DATE OF BIRTH				DATE OF DEATH			
DATE OF BIRTH				RELATIONSHIP				DATE OF BIRTH				DATE OF DEATH			
MO DAY YR				MO DAY YR				MO DAY YR				MO DAY YR			
12 25 10				12 25 10				12 25 10				12 25 10			
31 15 34				31 15 34				31 15 34				31 15 34			
255.00 DGR				255.00 DGR				255.00 DGR				255.00 DGR			

U.S. O.A.C. 74, 8-68.

9

56

☐ PRIOR ACTION (SEE OVER)

REQUEST FOR E/R ACTION

REQUESTING OFFICE BROOKLYN 26 NY				CODE 127 03	REQUEST DATE 11 69	TYPE ACTION EST	BLOCK NUMBER A 18818N	ACCOUNT NUMBER 061-34-9246											
NAME OF A/N HOLDER KAUFMAN, LILLIAN				SEX F	DATE OF BIRTH 07 15 12		DATE OF APPL.	TYPE CLAIM L	DATE OF DEATH										
MULTIPLE A/N		MULTIPLE A/N		MILITARY SERVICE FROM THRU		USE	MILITARY SERVICE FROM THRU		USE										
LAG INFORMATION FURNISHED BY DISTRICT OFFICE																			
TYPE	PERIOD	AMOUNT	EIN	TYPE	PERIOD	AMOUNT	EIN	R.R. SERVICE	MO. ELECT										
									FORM 805										
								AUXILIARY OR SURVIVOR DATA											
								SEQ 14827											
REMARKS UNIT DIB																			
										F					M				
										N					N				
										P					R				

FORM OA-C790 (10P) (6-68)

Form W-2

U.S. Treasury Department
Internal Revenue Service**WAGE AND TAX STATEMENT**
Keep this copy as part of your tax records.

Copy C—For employee's record

1968

INCOME TAX INFORMATION		SOCIAL SECURITY INFORMATION		STATE OR MUNICIPAL INFORMATION	
Federal income tax withheld	Wages paid subject to withholding in 1968	Other compensation paid in 1968	F.I.C.A. employee tax withheld 3	New York State Tax Withheld	New York City Tax Withheld
1343.00	10,600.00		343.20	313.40	62.55

Type or print EMPLOYEE'S social security number, name and address below

065-01-5460

Murray Kaufman
1225 Ocean Parkway
Brooklyn, N.Y. 11230Type or Print
EMPLOYER'S
Name, address
and address

C M C INDUSTRIES INC.

520 Eighth Avenue

New York, N. Y. 10018

13-2535674

Single	No. of
Married	Depen-
	dents
M	2

1 Includes tips reported by employee. Amount is before all deductions or sick pay exclusion.
 2 Add this item to wages in figuring the amount to be reported.
 3 Wages and salaries on your income tax return.
 4 The Social Security (F.I.C.A.) rate of 4.4% includes .6% for Hospital Insurance, Benefits and 3.8% for old-age, survivors, and disability insurance.
 5 Includes tips reported by employee.

Uncollected Employee Tax on Tips - \$

Form W-2 U.S. Treasury Department Ann. IRS 2-68

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Exhibit No.

This Certificate Witnesseth,

that on the 5th day of the week, the 21st day
of the month Lebeth in the year 56 96, A. M.,
corresponding to the 15th day of an 1936 the
holy Covenant of Marriage was entered into at Trotsky's
between the Bridegroom Murray Kaufman
and his Bride Lillian Goldsmith

The said Bridegroom made the following declaration to his Bride:

"Be thou my wife according to the law of Moses and of Israel. I faithfully
promise that I will be a true husband unto thee. I will honor and cherish thee;
I will work for thee; I will protect and support thee, and will provide all that
is necessary for thy due sustenance, even as it beseemeth a Jewish husband
to do. I also take upon myself all such further obligations for thy maintenance,
as are prescribed by our religious statute."

And the said Bride has plighted her troth unto him, in affection and in
sincerity, and has thus taken upon herself the fulfillment of all the duties incumbent
upon a Jewish wife.

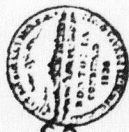
This Covenant of Marriage was duly executed and witnessed this day, according
to the usage of Israel.

Lillian Goldsmith Murray Kaufman
Bride Bridegroom
Rabbi Saul Bailly
Minister
He Schneider S. Bailly
Witness Witness



קול חתן וקול כלה.

[illegible]



HEALTH DEPARTMENT—REGISTRY DIVISION, CITY OF BOSTON
COUNTY OF SUFFOLK, COMMONWEALTH OF MASSACHUSETTS, UNITED STATES OF AMERICA

CERTIFIED COPY OF RECORD OF **BIRTH** IN OFFICE OF THE CITY REGISTRAR

Certificate No. 21490

AA

I, the undersigned, hereby certify that I held the office of _____
Records of Births, Marriages and Deaths required by law to be kept in said City; and I certify that the following facts appear on said Records.

No. 7790 Date of Birth July 15, 1912 Name of Child Lillian Isobel Smith
City Registrar of the City of Boston, and have the custody of the

Sex W. Color White Name, Surname and Birthplace of Father Joseph R. Isoldaniel NAME, MAIDEN NAME AND BIRTHPLACE OF MOTHER Matilda Lehman
Place of Birth Russia Residence of Parents Germany

30 Cheston St., Boston,
Boston, Mass., Mass.
Occupation of Parent _____

Name and Address of Informant _____
Shoe Merchant _____
Date of Record July 22, 1912

I further certify that by annexation, the Records of the following-named
cities and towns are in the custody of the City Registrar of Boston:—

ANNEXED	ANNEXED
East Boston.....1637	Charlestown.....1874
South Boston.....1804	Brighton.....1874
Roxbury.....1868	West Roxbury.....1912
Dorchester.....1870	Hyde Park.....1912

WITNESS my hand and the SEAL of the CITY REGISTRAR
on this 17 day of Oct, A. D. 1912

Charles H. MacKie

By Chapter 314 of the Acts of 1892, "the certificates or attestations of either Assistant
City Registrar shall have the same force and effect as that of the City Registrar."

City Registrar

BEST COPY OBTAINABLE

39

PP 2/69 — 8/72 61



REPORT OF DISABILITY INTERVIEW
(Write Legibly)

OFFICE

FLATBUSH

CONTACT MADE

☒ BY PERSON

☐ TELEPHONE

DATE

3/10/69

PLACE OF CONTACT

☒ HOME ☐ CS ☐ OTHER

ACCOUNT NUMBER

005-01-5460

CLAIMANT'S NAME

WILLIAM KAUFMAN

WAGE EARNER'S NAME (If not the claimant)

LILLIAN KAUFMAN

PERSON(S) CONTACTED

NATURE OF INJURY OR ILLNESS

HEART

JOB TITLE (Principal occupation)

none

CURRENT AGE

56

HIGHEST GRADE COMPLETED

H.S. GRAD.

OTHER TRAINING

TYPE OF BUSINESS OR INDUSTRY

INTERVIEWER'S SIGNATURE

Chusen

☒ CR ☐ FR

☐ OTHER

I. ONSET OF IMPAIRMENT

A. DATE INJURY OR ILLNESS FIRST BOTHERED CLAIMANT

1965

B. DATE CLAIMANT STOPPED WORKING

C. AOD

1965

Describe effect of impairment on work when condition first bothered claimant.

- Symptoms
- Job duties
- Working conditions
- Attendance

Describe significant changes (with dates) until work stopped.

- Symptoms
- Job duties
- Working conditions
- Attendance

Give claimant's reasons for stopping work.

Explain if AOD later than date claimant stopped work.

CLAIMANT BEGAN EXPERIENCING CHEST PAINS ABOUT 3-4 YEARS - SHE ALSO BEGAN HAVING DIZZY SPELLS & HAVING FAINTING AT FIRST THE DOCTORS THOUGHT ALL SYSTEMS WERE DUE TO A BLOOD PUMP SHE HAD MANY YEARS AGO - FOR PAST THREE YEARS CLAIMANT TELLS SHE WOULD HAVE BEEN UNABLE TO WORK DUE TO DIZZINESS & CHEST PAINS

Control rate 8/1/68

Has claimant worked since the alleged onset date? (If "Yes," complete Form OA-D821.)

☐ YES ☒ NO

If any apply, the decision will most likely rest on the medical reports or SGA.

CHECK ANY OF THE FOLLOWING THAT APPLY (If any of the items are checked—Do Not Complete pages 2, 3, or 4.)

- ☐ Is engaging in SGA
- ☐ Is hospitalized for a condition related to the alleged disability
- ☐ Loss of use of at least two limbs
- ☐ Alleges progressive cancer
- ☐ Is unable to speak, or to see, or to hear
- ☐ Has lost a leg because of diabetes or Buerger's disease
- ☐ Has lost use of a leg because of a fractured vertebrae

Exhibit No.

14
P 104411

II. PROGRESSION OF CONDITION

Have there been any changes in symptoms, physical limitations, or activities since work stopped?

☒ Yes

☐ No

62

in 9/68 CLAIMANT WAS IN HOED
FOR A D/C - IN THE COURSE
OF THE TEST THEY DISCOVERED
THAT SHE HAD A HEART
CONDITION

If yes, describe all changes in condition (with dates) since work stopped.

III. EFFECTS OF CURRENT CONDITION

CLAIMANT EXPERIENCES
CONTANT CHEST PAINS - EXCEPT
WHEN AT ABSOLUTE REST -
SHE ALSO HAS SHORTNESS WHEN
SHE DOES ANY WALK - SHE
MUST TAKE NITRO WHEN
SHE TRIES TO DO ANY
WALKING ON IN WINDY
WEATHER. DR SAY SHE MUST
NOT EXERT HERSELF IN ANY WAY
SHE IS ON A LOW CHOLESTEROL
DIET - SHE TAKES NITRO -

Describe current condition

- Symptoms - Type, frequency, severity
- Normal Activity limitations
- Other limitations

Physician placed limitations

- Bed rest
- Special therapy
- Diet
- Restricted activity
- Etc.

ISODAL - TRANQUILIZERS - INJECTIONS
OF VITAMINS THREE TIMES A WEEK

IV. DAILY ACTIVITIES

FOR DIZZINESS BECAUSE PALSY.

CLAIMANT LIVES IN 4 ROOM APT.
ELEVATOR. SHE IS NOT ABLE TO
DO ANY HEAVY HOUSEWORK - SHE
DOES NOT DRIVE A CAR SPENDS
MOST OF TIME AT HOME
MUST SIT & ELEVATE FEET
DURING THE DAY - MUST
EAT SEVERAL SMALL MEALS DAILY

Describe activities of a typical day

- Physical
- Mental
- Contact with others

Describe assistance required in caring for personal needs.

Describe current living arrangements.

CHECK ANY OF THE FOLLOWING THAT APPLY

(If any of the items are checked - Complete Observations (Section VII) and Omit Sections V and VI Only)

- ☐ Is house confined because of a physical impairment
- ☐ 3 months after stroke claimant has weakness of 2 limbs, or severe speech or memory defect with marked loss of use of one limb
- ☐ Arthritis with gross deformity of 2 or more limbs

- ☐ Parkinson's disease with marked tremors or propulsive gait.
- ☐ Multiple sclerosis with staggering gait, marked tremors or visual difficulties
- ☐ Other severe, observable limitations (Describe under Observations (Section VII).)

If any apply, a description of the impairment and observations are needed to supplement the medical reports.

(If Additional Space Is Needed Use Form OAC-5002)

V. WORK EXPERIENCE

63

List all types of jobs held in 15 years before onset

• Job title
• Approximate dates worked
List all job titles and dates worked since claimant began working where claimant

• Is age 55 or older, and
• Has 6th grade education or less, and
• Performed only arduous unskilled labor

Did claimant's last job before onset involve an occupation different from the principal job?
(If "Yes," describe in Section VI of a separate SSA-401.)

☐ Yes ☐ No

VI. PRINCIPAL JOB (Vocational Description)

A. JOB IDENTIFICATION

APPROXIMATE DATES WORKED	HRS./DAY	DAYS/WEEK	RATE OF PAY OR AVERAGE EARNINGS
			\$ PER

B. PHYSICAL DEMANDS

Describe each "Yes" item in terms of:

- Weight
- Distance
- Time
- Frequency
- Etc.

Use space for narrative description of physical demands where:

• Items above are not appropriate

• Supplemental description of item(s) would be helpful (e.g., human or machine assistance required to move heavy weights.)

1. Lifting	<input type="checkbox"/> YES <input type="checkbox"/> NO	How much in lbs.? _____	How often? _____	How High? _____
2. Carrying	<input type="checkbox"/> YES <input type="checkbox"/> NO	How much in lbs.? _____	How often? _____	How far? _____
3. Pushing/pulling	<input type="checkbox"/> YES <input type="checkbox"/> NO	How much in lbs.? _____	How often? _____	How far? _____
4. Standing	<input type="checkbox"/> YES <input type="checkbox"/> NO	How much time/day? _____		
5. Walking	<input type="checkbox"/> YES <input type="checkbox"/> NO	How much time/day? _____		
6. Sitting	<input type="checkbox"/> YES <input type="checkbox"/> NO	How much time/day? _____		
7. Climbing	<input type="checkbox"/> YES <input type="checkbox"/> NO	How high? _____	How often? _____	
8. Stooping, bending and/or kneeling	<input type="checkbox"/> YES <input type="checkbox"/> NO	How often and/or how long? _____		
9. Describe arm and hand manipulation in terms of (1) degree of coordination needed, (2) whether movements are gross or fine, (3) how often, and (4) how long.				
10. Driving	<input type="checkbox"/> YES <input type="checkbox"/> NO	How often and/or how long? _____		

(If Additional Space Is Needed, Use Form OAC-5002)

VI. PRINCIPAL JOB (Vocational Description) - continued

☐ Dust ☐ Noise ☐ Exposure to Elements ☐ Extremes in Temperature ☐ Work Pressure ☐ Dampness
☐ No adverse working conditions ☐ Other

C. WORKING CONDITIONS

Describe each item checked except "No adverse working conditions"

D. JOB DUTIES Describe fully each of the duties performed by the claimant in a typical day, including the amount of supervision received

1. Training—other than on-the-job received ☐ Yes ☐ No

2. Special qualifications or skills required ☐ Yes ☐ No

3. Supervision of others required ☐ Yes ☐ No

E. REQUIRED SKILLS

Describe all "Yes" answers fully.

VII. OBSERVATIONS

Sight ☐ Yes ☒ No
 Reading ☐ Yes ☒ No
 Responding ☐ Yes ☒ No

Hearing ☐ Yes ☒ No
 Use of hands and arms ☐ Yes ☒ No
 Writing ☐ Yes ☒ No
 Speaking ☐ Yes ☒ No

Comprehending ☐ Yes ☒ No
 Breathing ☐ Yes ☒ No
 Sitting ☐ Yes ☒ No
 Walking ☐ Yes ☒ No
 Other ☐ Yes ☒ No

Check each item to the left to indicate whether or not any difficulty was observed.

Came to office by
 TAXI. 5' 3" - weighs 148
 NO EVIDENCE SIGN OF DISABILITY

Describe fully
 • General appearance
 • Behavior
 • Outward attitude
 • Circumstances surrounding the interview
 • ALL ITEMS CHECKED "YES."

(If Additional Space is Needed, Use Form OAC-5002.)

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REPORT OF CONTACT

(USE INK OR TYPEWRITER)

REVIEWING OFFICE	ACCOUNT NUMBER (and symbol) 5460	65
TO: NY P BIR CH SF DBS KC DFC SA	NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON Lillian Kaufman	
PERSON(S) CONTACTED AND ADDRESS(ES): <input type="checkbox"/> WE OR SE PERSON <input checked="" type="checkbox"/> OTHER (Specify)		

CONTACT MADE: <input type="checkbox"/> DO <input type="checkbox"/> BO <input type="checkbox"/> CS <input type="checkbox"/> HOME <input checked="" type="checkbox"/> PHONE: IN 94600 <input type="checkbox"/> OTHER (Specify)		DATE OF CONTACT 4/23/69
--	--	-----------------------------------

SUBJECT: **Purpose: Follow-up on 250 letter mailed on 4/14/69.**

Facts: The secretary stated that she would bring the letter to the doctor's attention right away.

D.A.: **FIX F.U. 5/5**

SIGNATURE M. Buccellato	<input type="checkbox"/> CR <input type="checkbox"/> FR <input type="checkbox"/> SR <input type="checkbox"/> CLAIMS CLERICAL <input type="checkbox"/> OTHER (Specify)	DATE OF REPORT 4/23/69
DISTRICT OFFICE	PAGE 15 OF	

FORM SSA-5002 (2-68)

U.S. GOVERNMENT PRINTING OFFICE: 1968 O-320-914
Exhibit No. **15**

DO NOT WRITE IN MARGIN

REPORT OF CONTACT

(USE INK OR TYPEWRITER)

REVIEWING OFFICE: TO: NY P BIR CH SF DBS KC DFC SA

ACCOUNT NUMBER (and symbol): 5460 66

NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON: Lillian KAUFMAN

PERSON(S) CONTACTED AND ADDRESS(ES): ☒ WZ OR SE PERSON ☒ OTHER (Specify)

CONTACT MADE: ☐ DO ☐ BO ☐ CS ☐ HOME ☒ PHONE: ☐ OTHER (Specify)

SUBJECT: Purpose: To find out how long Dr. has been treating her for a heart condition. DATE OF CONTACT: 5/1/69

Facts: Mrs. Kaufman first came under Dr. Mandelbaum's care in November, 1968, following her hospitalization in 12/68.

Next Action: Prepare determination

SIGNATURE: M. Buccellato

DISTRICT OFFICE: ☐ CR ☐ FR ☐ SR ☐ CLAIMS CLERICAL ☐ MAN. MANUAL ☐ OTHER (Specify)

DATE OF REPORT: 5/1/69

PAGE 1 OF 1

FORM SSA-5002 (2-68)

U.S. GOVERNMENT PRINTING OFFICE: 1969 O - 220-914

Exhibit No.

DO NOT WRITE IN MARGIN

CORRESPONDENCE ROUTING			
<input type="checkbox"/> DIC	<input type="checkbox"/> AUTH DIS	<input type="checkbox"/> CEB	<input type="checkbox"/> RECOV
<input type="checkbox"/> DIC-BL	<input type="checkbox"/> CEU	<input type="checkbox"/> DIS-GI	
<input type="checkbox"/> DCE (AUTH)	<input checked="" type="checkbox"/> PEB 1068	<input type="checkbox"/> DIS-SC	
<input type="checkbox"/> DCE (CDB)	<input type="checkbox"/> DAS	<input type="checkbox"/> NR	
<input type="checkbox"/> DCE (REP)	<input type="checkbox"/> DT	<input type="checkbox"/>	

67

REPORTING CARD
NAME OF PERSON OR PERSONS ABOUT WHOM REPORT IS MADE
William Kaufman
ENTER SOCIAL SECURITY CLAIM NUMBER IN THIS SPACE
065-01-5460W-

DEPENDENCE ASSIGNMENT RECORD
Distribution Section)

Check or fill in ONLY the change being reported. Please do not send in this card unless there is a change to be reported.

1. ☐ CHANGE OF ADDRESS (Print new address at bottom)
Check if change is for: ☐ More than 6 mos. ☐ 6 mos. or less
To avoid delay in receipt of checks you should also file a regular change of address notice with your local post office.

2. ☐ WORKING AND WILL EARN OVER \$1,680 THIS YEAR:

I am working for wages of more than \$140 a month (or rendering substantial services in self-employment) beginning with the month of.....

Fill in both boxes

I estimate that my total earnings for this taxable year will be.....

3. ☐ STOPPING WORK:

The last month I worked for wages of more than \$140 (or rendered substantial services in self-employment) was.....

4. ☐ SIGNIFICANT CHANGE IN ESTIMATE:

I estimate that my total earnings for this taxable year will be.....

5. ☐ DEATH.....

6. ☐ GOING OUTSIDE THE U.S.

Name of country to which going.....

7. ☒ MARRIAGE

Place of marriage (City, County & State)
Beacon L.G. N.Y.

8. ☐ DIVORCE.....

9. ☐ ANNULMENT.....

10. ☐ CHILD LEGALLY ADOPTED BY:

☐ Stepparent ☐ Grandparent

☐ Aunt ☐ Uncle ☐ Brother

☐ Sister ☐ Other

11. ☐ CHILD OR OTHER CLAIMANT LEFT YOUR CARE.....

SIGNATURE OF PERSON MAKING THIS REPORT

William Kaufman Goldberg
NUMBER AND STREET, P.O. BOX, OR ROUTE
1225 Ocean Parkway-Apt 3C
CITY Bklyn STATE NY ZIP CODE 11230
DATE SIGNED 5/16/72 TELEPHONE NUMBER, IF ANY
Des-6907
ENTER NAME OF COUNTY, IF ANY, IN WHICH YOU LIVE
KINGS

PRINTING OFFICE: 1971-0-5-039/175

Exhibit No.

17

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68

HUGH A. JONES
 STATE BOARD OF SOCIAL WELFARE
 GEORGE K. WYMAN
 COMMISSIONER
 C. CARLYLE NUCKOLS, JR., M.D.
 DEPUTY COMMISSIONER

STATE OF NEW YORK
 DEPARTMENT OF SOCIAL SERVICES
 BUREAU OF DISABILITY DETERMINATIONS
 110 WILLIAM STREET
 NEW YORK, N. Y. 10038
 Telephone - Area Code 212 - 488-2214

STATE OF NEW YORK
 DEPARTMENT OF SOCIAL SERVICES
 BUREAU OF DISABILITY DETERMINATIONS
 69 JUN 19 AM 10:48
 SIDNEY HUBBEN
 DIRECTOR

Harold Mandelbaum, M. D.
 380 East 18th Street
 Brooklyn, N. Y. 11226

Date: APR 14 1969

Re: Lillian Kaufman
 1225 Ocean Pkwy
 Brooklyn, N. Y.
 A/N: 065-01-5460
 Date of Birth: 7/15/12

Dear Dr. Mandelbaum:

Thank you for submitting a report to the Social Security Administration on your patient's behalf. As you may know, it is the responsibility of this office to make a determination of disability under the provisions of the Social Security Act.

We regret having to contact you again but additional information is needed in order to properly evaluate the above claimant's impairment. We require photocopies of the most recent EKG tracings showing left bundle branch block. If photocopies are not available, please submit original which we will photocopy for our files and then return to you. If the above is not possible, a detailed qualitative description of the tracing will be appreciated.

A copy of your initial report is enclosed, as well as a return envelope for your convenience.

Under the law, it is the claimant's responsibility to furnish medical evidence in support of his application; we therefore cannot pay for this service. Your cooperation in this matter will be most helpful in our making a prompt decision regarding your patient's application.

Sincerely yours,

Joseph J. Oliver, M.D.

Joseph J. Oliver, M. D.
 Chief Medical Consultant

MB:cb U-5 A-10
 Enclosure
 DF-250 (Spec)

BEST COPY OBTAINABLE

Kindly return to this office

cc to...

YOU MAY RETAIN THIS COPY FOR YOUR RECORDS OR DESTROY

69

BENJAMIN ROSENBERG, M. D., F.A.C.P.

HAROLD L. MANDELBAUM, M. D.

RICHARD RUBIN, M. D.

STATE OF NEW YORK
DEPARTMENT OF SOCIAL SERVICES

380 EAST 18TH STREET
BROOKLYN, N. Y. 11226

'69 JUN 19 AM 10:48

VERBOLL 9-4600-1

BUREAU OF
DISABILITY DETERMINATIONS

March 5, 1969

RE: LILLIAN G. KAUFMAN

TO WHOM THIS MAY CONCERN:

Mrs. L. G. Kaufman has been under my care for anginal syndrome and arteriosclerotic heart disease. On electrocardiogram a left bundle branch block is present. Her cardiac classification is 2B.

Yours very truly

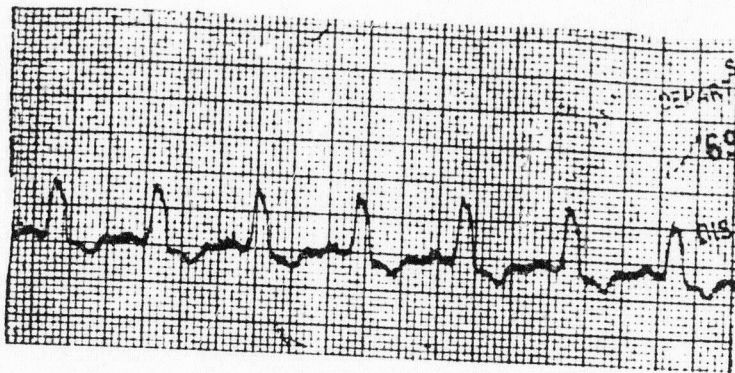
Harold L. Mandelbaum
HAROLD L. MANDELBAUM, M.D.

HLM/r

PATIENT _____

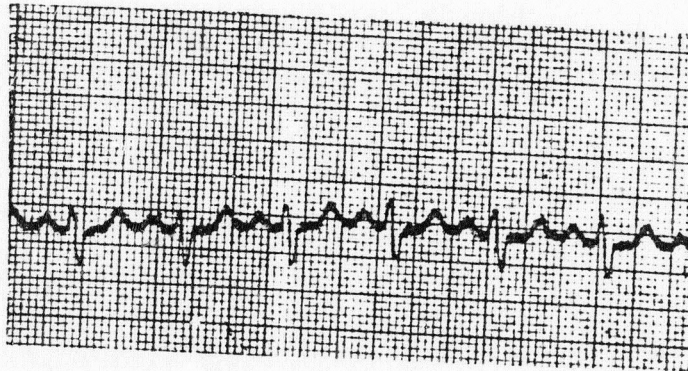
File Copy
70

LEAD 1



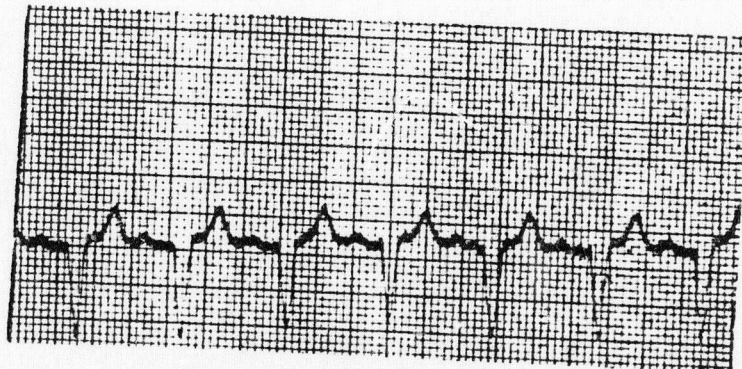
6 SEC.

LEAD 2



6 SEC.

LEAD 3



TRIAL RATE _____ P-R INTERVAL _____ PATIENT POSITION _____
ENTRICULAR RATE _____ QRS INTERVAL _____ ELECTRICAL AXIS _____
HYTHM _____ Q-T INTERVAL _____ S-T SEGMENT _____
WAVES _____ T WAVES _____
MARKS _____

PATIENT _____ ROOM NO. _____ AGE _____ SEX _____ DATE _____
ADDRESS _____
DOCTOR _____ CASE NO. _____ PHONE _____
SERIAL NO. _____

NEW YORK SERVICES
69 JUN 19 AM 10:40
BUREAU OF
DISABILITY DETERMINATIONS

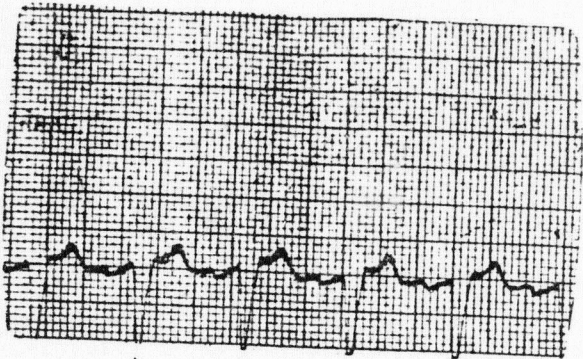
Lillian G Kaufman
5-14-10

3

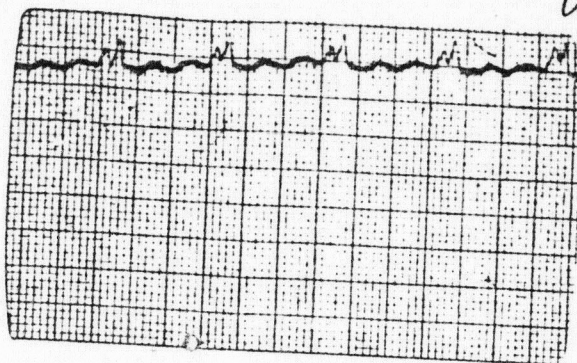
PATIENT

file copy 71

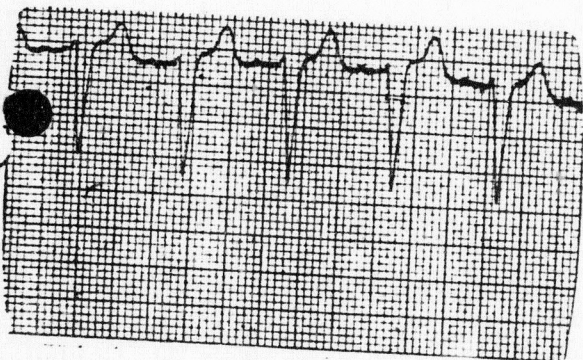
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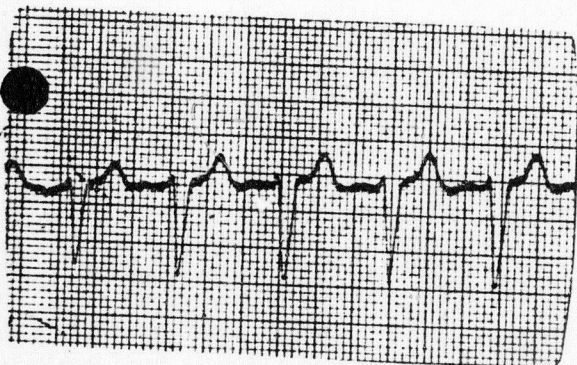
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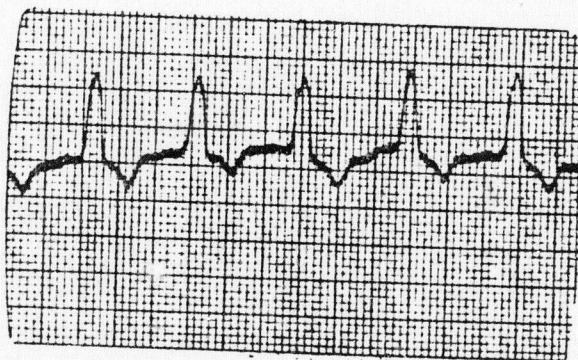
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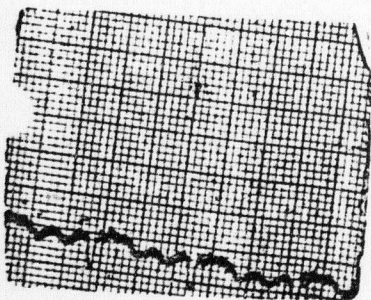
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V₆

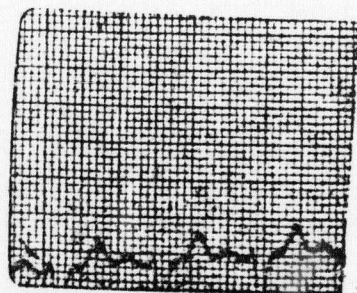


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AVL

AVF



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ORDER BY NO. C-12.5

4

PATIENT

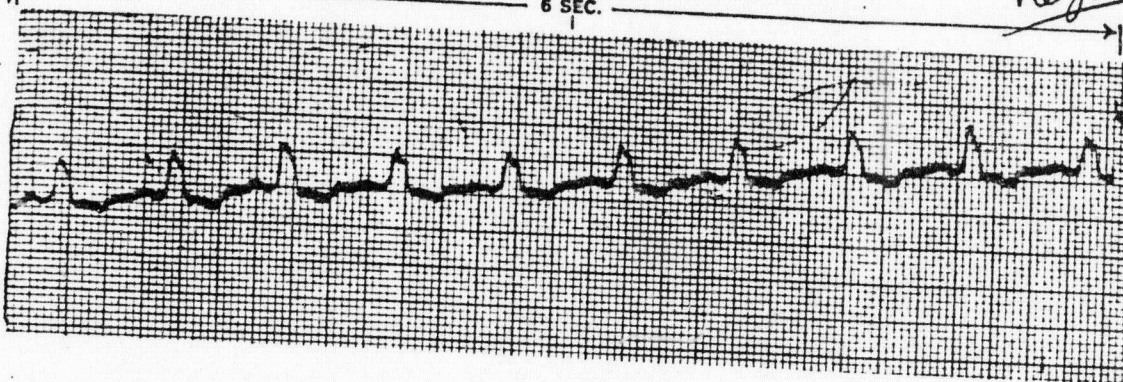
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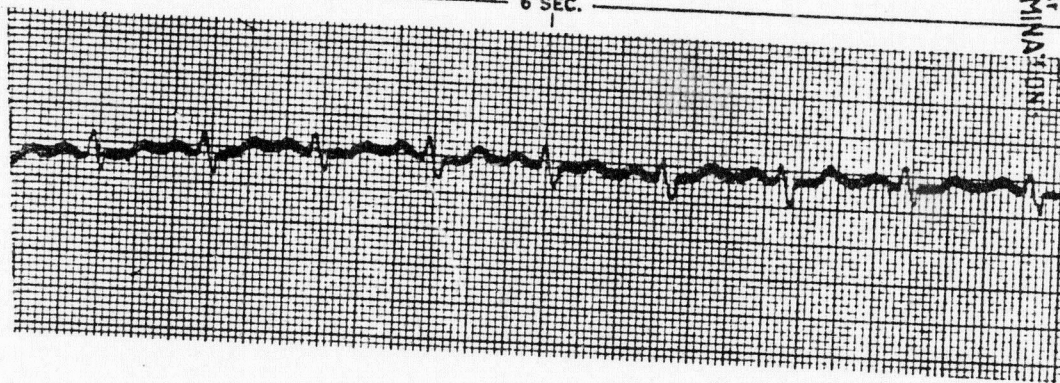
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72

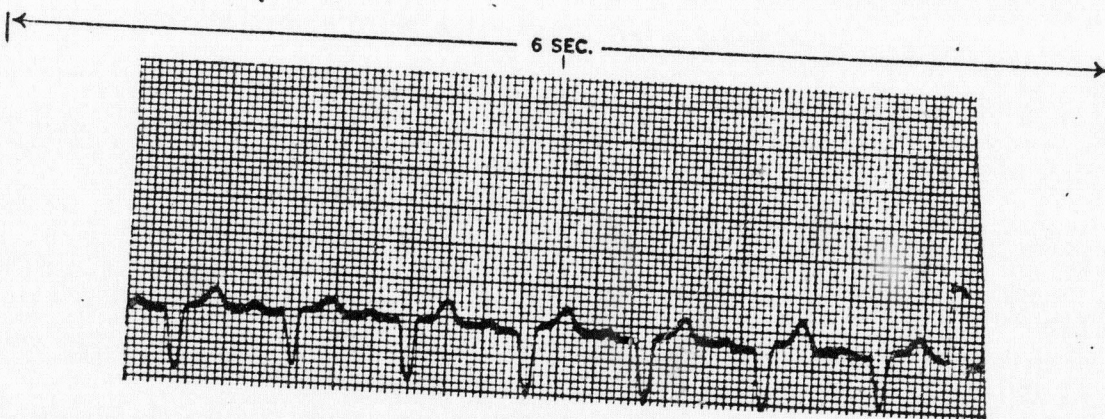
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LEAD 2



LEAD 3



MAY - 1 1969
BUENOS AIRES
CLINICA TERMINAL

PATIENT _____
ADDRESS _____
DOCTOR _____
ROOM NO. _____
AGE _____
SEX _____
DATE _____
PHONE _____
CASE NO. _____
SERIAL NO. _____

AURICULAR RATE _____ P-R INTERVAL _____ PATIENT POSITION _____
VENTRICULAR RATE _____ Q-R-S INTERVAL _____ ELECTRICAL AXIS _____
RHYTHM _____ S-T SEGMENT _____
WAVES _____

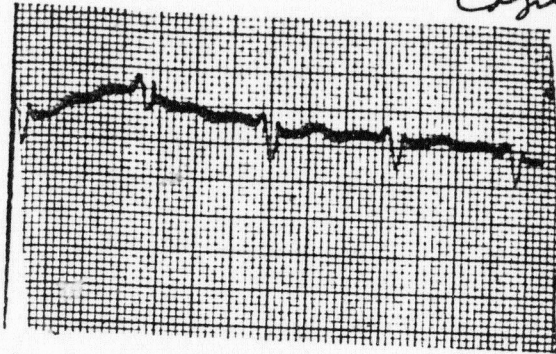
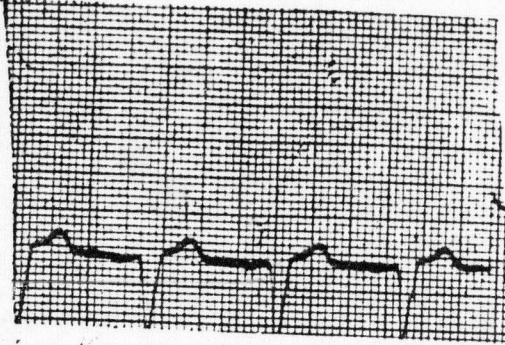
Heleen Kaufman
1/8/69

PATIENT

Page -

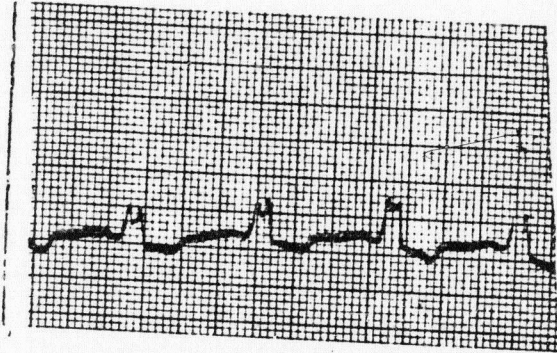
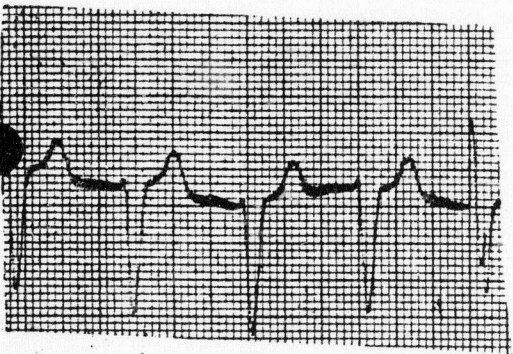
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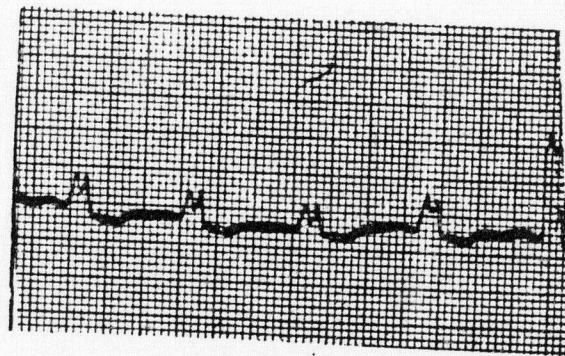
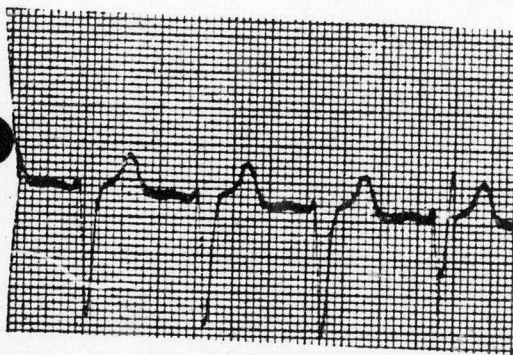
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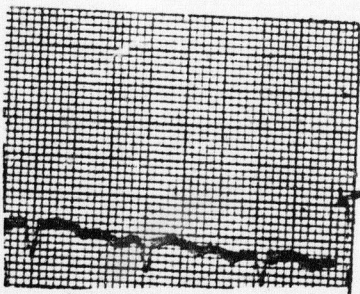


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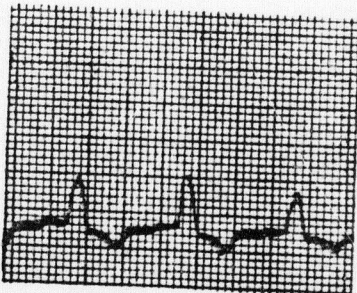
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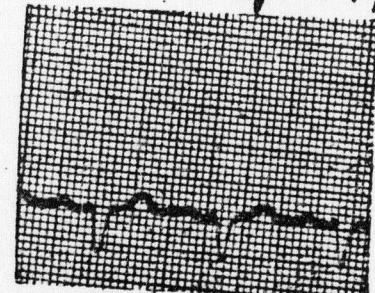
LEAD
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CF₆
CL₆
CR₆



LEAD VR AVR



LEAD VI AVI



LEAD V6 AVI

Exhibit No. 18
(P. 6 of 6 pp)

W.D. FOR NECHIN & BEVERIDGE, INC.
229 S. WOOD STREET, CHICAGO 60612
PRINTED IN U.S.A.
ORDER BY NO. C-12-8

1. Physician's Name Mandelbaum Harold
(Last) (First) (Middle)
2. Address 380 East 18th Street, Brooklyn, N.Y. 11226 74

3. Year of Birth (B): 1930

4. Medical Education (ME): State: New York

School: State University of New York Downstate Medical/
Center, N.Y.-Bklyn.
Year of Degree: 1954

5. Year of License (L): 1955

6. American Specialty Boards (AB): American Board of Internal Medicine

7. Medical Specialties: Internal Medicine

8. Type of Practice (TOP): Internal Medicine

9. National Scientific Medical Societies (SS): Member, American Medical Association

10. Professorial Appointments (PA): State: _____

School: _____

Title & Current Status: _____

11. Other Information (e.g., Hospital Appointments): _____

12. Sources of Information:

American Medical Directory
Year: 1967 Edition: 24th Page: 2412

Other Sources: _____

KINGS HIGHWAY HOSPITAL
3201 KINGS HIGHWAY
BROOKLYN, N. Y. 11234
CLOVERDALE 2-3000

75

March 13, 1969

Dept. of Health, Ed. & Welfare
135 E. 22 St.
Brooklyn, N.Y.

Re: Lillian Kaufman #66845
Your # 065-01-5460

Gentlemen:

This is in compliance with your request for information on the above patient:

Date of admission: 10-27-68

Date of discharge: 10-31-68

Final diagnosis: Post menopausal bleeding

History: Patient is a 56 year old white female admitted to the KHH for the first time for a D & C. Patient describes her bleeding as clots. Patient has a history of a D & C 2 years ago for similar complaints.

X-ray 10-27-68: Chest, teleo
Conclusion: Negative

Operation 10-28-68: D & C

Pathology 10-28-68: Urine Curettings
Diagnosis: Small fragments of non cancerous endo
and exo cervix.

EKG 10-27-68: I v conduction defect, LBBB type. Poor R wave progression to v3. T negative in I, avl, v6, Tv5 diphasic. Consistent with myocardial damage. ? of ant-septal infarction - age??

10-29-68: LBBB

Condition on discharge: Improved

I hope that the above information will be of assistance to you.

Very truly yours,

Jane T. Cerbone
(Mrs.) Jane T. Cerbone, R.R.L.

JTC:dh

Exhibit No.

20

MEDICAL REPORT
(General)

Notice to Physician:

Please include sufficient details of history, physical and diagnostic findings, clinical course, therapy and response to enable a reviewing physician to make an independent determination as to the severity and duration of the impairment.

DATE OF THIS
REQUEST

3/10/69

(1) IDENTIFYING INFORMATION (To be completed by Requesting Office)	PATIENT'S NAME	DATE OF BIRTH	SOCIAL SECURITY ACCOUNT NO.
	Lillian Kaufman	7/5/17	065-015460
	WAGE EARNER'S NAME (If different from patient)	ADDRESS OF REQUESTING OFFICE	
	Murray Kaufman	135 EAST 22ND ST B'klyn NY	
	NAME OF DOCTOR		
	Dr J. Cinner		

I. HISTORY: (Give complaints, past and present, clinical course, including therapy and response.)

Patient complained of pain in right cheek
and forehead with closure of right eye
sometime in 1965.

Sent for x-rays

Vit B1 + B12 injections

There are times when above symptoms
are less pronounced

DATE OF INJURY OR FIRST SIGNS OF ILLNESS	DATE IMPAIRMENT PRE- VENTED WORK	DATE YOU FIRST EXAMINED PATIENT	FREQUENCY OF VISITS	DATE OF LAST EXAMINA- TION
1965	never worked	1965	1 to 3x weekly	3/17/69

FORM SSA-826 (7-67)

Exhibit No.

21
(PI) 6377

II. PHYSICAL FINDINGS: Please show all pertinent findings (with dates).

HEIGHT

5' 2 1/2"

WEIGHT

158

77

Negative

III. LABORATORY AND SPECIAL STUDIES: Give results with dates. (Hemoglobin, Hematocrit, Sedimentation rate, Cerebrospinal fluid, Blood chemistry, Urinalysis, Sputa (smear, culture), Serology, X-rays, Electrocardiogram, Liver function, Bronchoscopy, Myelogram, Biopsy, Pulmonary function, Renal function, Psychometric, etc.)

78

X-ray of face & skull on 6/28/65
Findings - Negative

IV. DIAGNOSES:

1.
2.
3.

Bells Palsy

REPORTING PHYSICIAN'S NAME AND ADDRESS

JULES OLINDER, M.D.
1890 OCEAN AVENUE
BROOKLYN 10, N.Y. 11219

SIGNATURE

Jules Olinder

TELEPHONE NUMBER

ES 7-7782

TITLE

DATE

MD
3/28/69

BEST COPY AVAILABLE

1. Physician's Name Cinder Julius
(Last) (First) (Middle)

2. Address 1590 Ocean Avenue, Brooklyn, N.Y. 11230 79

3. Year of Birth (B): K9XX 1913

4. Medical Education (ME): State: Scotland
School: Registrable Qualification granted by Scottish/ land
Conjoint Board, Scot-/
Year of Degree: 1940

5. Year of License (L): 1940

6. American Specialty Boards (AB):

7. Medical Specialties: General Practice - Allergy

8. Type of Practice (TOP): General Practice - Allergy

9. National Scientific Medical Societies (SS): Member, American Medical Association
American Academy of Allergy
American Psychiatric Association
American Academy of General Practice

10. Professorial Appointments (PA): State: _____
School: _____
Title & Current Status: _____

11. Other Information (e.g., Hospital Appointments): _____

12. Sources of Information: American Medical Directory
Year: 1967 Edition: 24th Page: 2396

Other Sources: _____

RECEIVED



"WITHOUT FAULT" QUESTIONNAIRE

MAY 10 1973
BHA - SSA
175 Reimsen Street
New York 11201

SOCIAL SECURITY CLAIM NUMBER

065-01-5460

NAME OF INSURED INDIVIDUAL

Lillian Goldberg

NOTICE - Whoever makes or causes to be made any false statement or representation of a material fact for use in determining a right to payment under the Social Security Act is subject to not more than a \$1,000 fine or 1 year of imprisonment, or both.

NAME OF OVERPAID PERSON(S)

Lillian Goldberg

1. Give the reasons you thought you were entitled to this payment

I recd no notice of termination until July 14/72

2.(a) How did you report events which require holding back or stopping your payments?

Mailed in card - notice of my marriage

(b) If you tried to hold your earnings down so that you could receive benefit payments, what did you do to limit your earnings?

3. When did a social security employee first explain to you the conditions under which you could receive benefits?

SIGNATURE OF OVERPAID PERSON OR REPRESENTATIVE PAYEE

Signature (First name, middle initial, last name) (Write in ink)

SIGN
HERE

Lillian Goldberg

Date (Month, day, year)

3/10/69

Telephone Number

De 8-6907

Mailing Address (Number and street, Apt. No., P.O. Box, or Rural Route)

City and State

1225 Ocean Parkway
Brooklyn New York

ZIP Code

11230

Enter Name of County (if any) in which you now live

Kings

Witnesses are required ONLY if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the individual must sign below, giving their full addresses.

1. Signature of Witness

Address (Number and street, City, State, and ZIP Code)

2. Signature of Witness

Address (Number and street, City, State, and ZIP Code)



REFUND QUESTIONNAIRE

To be completed by individual who alleges
inability to repay debt due the
Social Security Administration

Form Approved,
OMB No. 72-R0318

SOCIAL SECURITY CLAIM NUMBER

065 | 01 | 54 | 60 | 81

NAME OF INSURED INDIVIDUAL

NOTICE. - Whoever makes or causes to be made any false statement or representation of a material fact for use in determining a right to payment under the Social Security Act is subject to not more than a \$1,000 fine or 1 year of imprisonment, or both.

NAME OF OVERPAID PERSON(S)

Lillian Gersberg

1. Do you have any of the incorrectly paid benefit checks in your possession? ☐ Yes ☒ No
If "Yes," show the total amount..... \$

THESE CHECKS MUST BE RETURNED IMMEDIATELY

2. List your total monthly income (including any income of your spouse or any dependent relative living in the household with you), from:

Social Security benefits

None



Wages (take-home pay)

Husband weekly

165.00 (1973)

Average net earnings from self-employment

Self none

Roomers or boarders

Service allotments (Army, Navy, etc.) and
Veterans Administration pension or compensation

Public assistance payments

Contributions from relatives (other than
dependent relatives whose income is included under wages)

Other, such as rentals, dividends, pension payments, etc. Explain.....

** Take home pay 1972 (\$0.00)*

None

TOTAL

165 weekly

3. Do you support, either fully or in part, anyone other than yourself? ☐ Yes ☒ No

If "Yes," list the name, address, age and relationship of each person whom you support.

NAME	ADDRESS	AGE	RELATIONSHIP TO YOU (If none, enter "None.")

6. (a) Not counting household furnishing or family automobile, do you, your spouse, or any dependent relative living in the household with you have any personal property, such as cash on hand, funds in bank, stocks, bonds, etc.? ☒ Yes ☐ No 83
If "Yes," answer (b).
(b) Give the amount of these funds.

Cash on hand \$
Amount of funds in bank, savings and loan association and credit union \$ 1900.00

Name and address of your savings institution:

Dime Savings and Bk.

Value of stocks and bonds 50 shares at 9.50 shares 475.00
Name the stocks and bonds you have:
Shearson Capital Fund Inc

Value of other personal property and other funds (trust funds, etc.) \$
Explain:

TOTAL \$ 2375.00

7. (a) Not counting the home in which you live, do you, your spouse, or any dependent relative living in the household with you own any real estate? ☐ Yes ☒ No
If "Yes," answer (b) and (c)

(b) What is the value of the real estate (DO NOT INCLUDE YOUR HOME) \$

(c) If mortgaged, state amount of the mortgage \$

8. Are all or any part of the incorrectly paid benefit amounts included in the funds or property listed in items 6 and 7? ☐ Yes ☒ No
If "Yes," show the amount and describe the nature of such funds or property.

IF A CHILD IS ALSO AN OVERPAID BENEFICIARY, THE FOLLOWING QUESTIONS SHOULD BE ANSWERED
9. Give the child's name and present address
None

10. Were the incorrectly paid benefit amounts used for this child? ☐ Yes ☐ No
Explain

(OVER)

11. Does the child have any:

(a) Income (including social security benefits).....

☐ Yes

☐ No

84

If "Yes," show monthly amount

\$

(b) Monthly expenses?

☐ Yes

☐ No

If "Yes," show monthly amount

\$

(c) Personal property, such as cash in bank, stocks, trust funds, bonds, etc.?

☐ Yes

☐ No

(Include funds held jointly)

If "Yes," how much and what kind? (List each item separately. Do not show the value of the household furnishings or family automobile.)

(d) Real estate other than his home?

☐ Yes

☐ No

If "Yes," show the total value: \$ and the amount of any mortgage \$

12. Are all or any part of the incorrectly paid benefit amounts included in the fund or property listed in 11(c) or (d)?

☐ Yes

☒ No

If "Yes," show the amount and describe the nature of such funds or property:

13. (a) Is child married?

If "Yes," answer (b) and (c)

☐ Yes

☐ No

(b) What is the spouse's monthly income?

\$

(c) What are their monthly expenses?

\$

REMARKS

I know that anyone who makes a false statement or representation of a material fact for use in determining a right payment under the Social Security Act commits a crime punishable under Federal law. I affirm that the above statements are true.

SIGNATURE OF PERSON COMPLETING QUESTIONNAIRE

Signature (First name, middle initial, last name) (Write in ink)

SIGN

HERE

Lillian Goldberg

Date (Month, day, year)

5/9/73

Telephone Number

De 8-6907

Mailing Address (Number and street, Apt. No., P.O. Box, or Rural Route)

City and State

1225 Ocean Parkway

ZIP Code

11230

Enter Name of County (if any) in which you now live

Kings

Witnesses are required ONLY if this questionnaire has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person completing the questionnaire must sign below, giving their full addresses.

1. Signature of Witness

2. Signature of Witness

Address (Number and street, City, State, and ZIP Code)

Address (Number and street, City, State, and ZIP Code)

RECEIVED
U. S. ATTORNEY

JUL 26 9 27 AM '76

EAST. DIST. N. Y.

*Paula
Garcia*